PUBLIC HEALTH NURSING

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ARE WE PREPARED?

This celebration of Mothers' Day unquestionably finds a stirring of interest and an awakening of social conscience in relation to the appalling toll of maternal deaths in the United States—a mortality rate which has remained practically stationary for the past twenty years, at around six maternal deaths per 1000 live births. The impasse which seemingly had been reached in large rural areas because of lack of funds has been broken by the provisions for grants-in-aid to the states under the Social Security Act. Under Title V of this Act the Federal Children's Bureau is made responsible for the allocation of funds to be administered by the state health departments, and all of the 48 states as well as the territories of Alaska and Hawaii and the District of Columbia have already taken advantage of these provisions to expand their maternal health program.

An increase of maternity nursing services is an important part of this program, and financially speaking, a large part. Communities that have never known an organized maternity nursing service now have the benefits of such a service. Nursing services that have heretofore offered only antepartum care are offering postpartum care, and more recently, care in confinement—that most critical time for mother and baby.

Interest has been focused on maternity, also, through the nation-wide program for the control of syphilis initiated during the past year by Dr. Thomas Parran, Surgeon General of the United States—a program in which the routine physical examination and Wassermann test of all pregnant women are vital factors in case-finding and the prevention of congenital syphilis.

Agencies giving intensive maternity service have long ago reduced their maternal death rate below that of the general area in which they are located, demonstrating what can be done. Individual communities, such as Syracuse, New York, have recently initiated campaigns to reduce their maternal mortality rate and provide good care to expectant mothers, and under the leadership of the local medical groups have stimulated an interest in better preparation on the part of physicians and nurses and awakened a public sensitivity to the problem.

Yes, something is happening in regard to maternal welfare! What, then, should be our major concern as nurses in this campaign to give a high standard of maternity care?

The greatest apprehension of public health nursing leaders at the present time is that many of the activities being

initiated may prove to be ineffective and fruitless efforts. Why? Because no matter what the *quantity* of maternity nursing service, its real effectiveness will depend on the *quality* of the service rendered. *Are we prepared,* as nurses, to carry out our part of the program? There is grave evidence that we are not—evidence based on the study of the White House Conference committee regarding the nurse's knowledge about obstetric nursing,* and on the failure of many communities to reduce their maternal mortality rate after many years of maternity-health service. Of course this failure may be due to many factors, some of them out of the control of the nursing service. Again, it may rest at our door, at least partially. Is the service we have rendered adequate, from the standpoint of furnishing care during the entire maternity cycle—antepartum, delivery, postpartum?

And *are we competent maternity nurses?* A specialist in maternity nursing was recently asked what is the greatest weakness in the functioning of maternity nurses. Her answer was, "They don't know *why* they do things."

Undoubtedly much of this weakness is no fault of ours. It is a failure in our basic preparation. How, then, can we remedy it? By having standard obstetrical books at hand and consulting them frequently. By keeping in touch with new developments in the field through current magazines and other publications (PUBLIC HEALTH NURSING is carrying an increasing amount of material on the content and methods of maternity nursing in response to the increasing demand from the field). By attending institutes and using the stimulation and guidance which they give us for further study afterward. By taking postgraduate courses. By asking the physician who is attending our patient during delivery, to teach us as he works. By attending lectures, demonstrations, and classes given by local obstetricians and maternity nursing instructors. One suggestion is for a visiting-nurse staff to arrange to attend lectures in a local nursing school, as a "refresher" in keeping up to date.

Let us not be caught unprepared to meet the challenge of this greatest opportunity we have ever had to reduce the maternal mortality rate and improve maternity health!

*The White House Conference. Obstetric Education. Report of the Subcommittee on Obstetric Teaching and Education. The Century Company, New York, 1932. Part II, pp. 123-149.

SCHOOL NURSING AND THE N.E.A.

WHEN the Joint Committee of the National Education Association and the American Medical Association made a preliminary study of school health policies, the returns from school administrators showed clearly the heavy measure of responsibility that is generally placed on school nurses. These replies also indicated appreciation of the nurse's contribution and of the generous spirit in which her services are performed. Studies of school health personnel made by Dr. J. F. Rogers of the U. S. Office of Education, over the last two decades, emphasize the considerable number of nurses employed in school health work—far more numerous than any other group—and the scope and importance of their services in the total program. These and other studies repeatedly stress the need for better and more specific training, to help school nurses to be still more useful in educational as well as public health phases of their work. Several states now make specific educational requirements for the school nurse, in addition to her preparation as a graduate, registered nurse and as a public health nurse; a number of colleges and universities are offering opportunity for this additional training and are finding an encouraging number

of competent nurses, women of good background and excellent personal qualifications, who are enrolling for these courses.

Administrative set-ups vary so widely that no general statement can be correct; but it may be said that in city school systems the customary plan is employment of school health personnel by the board of education, though a few great cities follow the plan of employment by the board of health. In either case, school nurses and physicians are responsible directly to the school authorities for their actions with regard to pupils, for there is no way in which school people can be relieved, or relieve themselves, of their legal and moral responsibility for everything affecting the welfare of school children during school hours.

The alert nurse soon recognizes that all school health work can be enormously reinforced by the intelligent help of the teaching staff. By providing a good setting for her health inspection service, by smoothing her whole routine, by helping with the final push which secures "corrections," the teacher is the nurse's one indispensable ally.

In country districts, school health personnel are more likely to be part of a public health unit, working on some more or less (and chiefly less) specific basis at improving child health and discovering adult needs through the schools. Here, all too often, paid medical supervision is lacking and whatever can be done for the children must be done by teacher and nurse. Yet, heavy though the country nurse finds her burden of responsibility, there is plenty of evidence to show that she and the school, working together, have fought valiant and successful battles with ignorance and inertia, poverty and laziness, superstition and stinginess.

The new public health program under the Social Security Act will probably emphasize and intensify this teacher-nurse partnership in rural districts.

With all this testimony as to the close relationship of nurse and school, it is somewhat remarkable that no organized group of school nurses, or of school physicians, are represented in the National Education Association. Many nurses are N.E.A. members, and at every meeting of the Department of School Health and Physical Education they have demonstrated their interest by attendance and participation. At the Portland meeting (July 1936), the Department was very fortunate in securing the participation of Ella McNeil, representing the National Organization for Public Health Nursing. Anna R. Moore, Advisory Public Health Nurse in the State of Washington and Olive M. Whitlock, Director of Public Health Nursing of the State Board of Health of Oregon, presented papers and took part in panel discussions. Local nurses' organizations gave hearty coöperation in making the Department dinner a success. While the officers of the Department were still feeling most grateful to the profession for all this good help, we were surprised to receive a number of letters from nurses expressing appreciation of the fact that nurses had had a place on the program! These expressions of interest have continued to come throughout the year. They have encouraged us to hope that school nurses will be interested in active participation and attendance at the Department meeting in Detroit, Michigan, June 28 to June 30, at which plans for the organization of a health division will be developed. Such a division would bring school nurses into active relationship with their coworkers in school health, and at the same time give them an opportunity to present their own views on educational problems.

A large share of responsibility for health instruction and health supervision is carried by physical-education teachers throughout the country. Physical education is quite generally a state requirement, though school medical and

nursing service may be left to local enterprise, or lack of it. It is of course essential that these groups understand each other's programs, policies, difficulties, and resources. Physical educators are organized in a great national organization, the American Physical Education Association, having some 8000 members, and publishing a very useful monthly, the *Journal of Health and Physical Education*. Since most of the American Physical Education Association members are employed as teachers in the public schools, many are already members of the National Education Association. For some years negotiations have been under way looking toward a merger of the Department of School Health and Physical Education of the National Education Association with the American Physical Education Association. If the present plans are accepted by the American Physical Education Association at its April meeting, the new Department will consist of a division of health, a division of physical education, and a division of recreation. It is earnestly hoped that school nurses may desire to participate in the activities of the division of health.

Sooner or later, it seems inevitable that the various groups of specialists who are responsible for school health work must come together, formulate policies, and make these policies known through the National Education Association, the agency which represents the concern of all of us, employed in public schools, for the welfare of all the children of all the people, entrusted to us by their parents and by the state. In this concern the nurse has a great and effective share; she should surely see to it that her voice is heard in the councils of school health workers and educators.

EDNA W. BAILEY, Ph.D.
President, The Department of School Health and Physical Education, National Education Association

Courtesy Safety Education

SURPRISE

THIS IS The Birthday Year of the N.O.P.H.N., but it is our readers who are getting the customary surprise, instead.

JUNE IS The Birthday Month and in its honor PUBLIC HEALTH NURSING will make its first appearance in a new frock.

IT WILL Be The Same Blue with which you have identified it for so many years, but the added use of white and more generous spacing than heretofore make it more pleasing and distinctive. The cover was designed by Johanna Hoffman, assistant on the editorial staff of the magazine.

WE HOPE YOU LIKE IT!

A Tribute to the Public Health Nurse

By LIVINGSTON FARRAND, M.D., LL.D., L.H.D.
President, Cornell University, Ithaca, New York

An old friend of public health nursing participates in the N.O.P.H.N. Silver Jubilee celebration and points to the need for more qualified public health nurses

FOR A good many years I have been both interested in and personally concerned with various aspects of the great public health movement, and it is inevitable that any one who has had that experience should come into touch with the nursing profession generally and more particularly with the visiting nurse and in these later years with the public health nurse—with all that that term and that individual mean for the general welfare.

I remember very vividly the beginning of the organized campaign against tuberculosis in this country and how we conceived of it first as a campaign of education. It was a matter of mass education. It was based upon the dramatic discoveries of medical science and their obviously possible application to the prevention of disease and to the administration of that application by public health authorities. We must remember that in those earlier days the conceptions of public health administration were rather crude. Of course there were certain essential things recognized—a pure water supply, a pure milk supply, etc.—but public health officers busied themselves chiefly with minor and not very important things. I sometimes used to feel that they were often more concerned with what were rather æsthetic considerations, such as sewer gas and other malodorous emanations. The objects were rather unpleasant but not very dangerous.

Then came a completely new conception. And in this tuberculosis campaign we found, I say, that the first thing to be accomplished was the education of the public. But soon we began to realize that after all it is not simply the education of the masses, except for the creation of a public opinion that will support official effort, that is necessary. But in the last instance if we are to get results we must come down to the individual and to his individual health habits. And the individual in his health habits is not to be reached effectively by the propaganda of organized agencies; he is going to be reached by the individual. And so we came to realize that the essential individual in this work was the visiting nurse, that there was nothing quite equal to her and her possibilities in the application of the knowledge of which I have just spoken. In saying that, one recognizes, of course, the indispensability of the medical profession and of the public health officials and of an enlightened public opinion.

Now what we found in the field of tuberculosis was found in the same way in the organized campaign against that civic blot—infant and child mortality, as well as in the case of various preventable infectious diseases. We are seeing it now in certain of the enemies that disable mankind; for example, in the present campaign, too long delayed, which is being inaugurated on a wide scale against venereal disease. Other

Address given at the Silver Jubilee luncheon of the National Organization for Public Health Nursing at the Hotel Roosevelt, New York, N. Y., March 18, 1937, and broadcast over National Broadcasting Company networks.

countries have demonstrated what can be done in checking the spread of syphilis and I am sure comparable results can be obtained in this country. And there remains another equally important challenge, and that is the whole field of mental hygiene, which calls for organized consideration in the same way.

Laboratories discover facts and it is one of the dramatic achievements of modern times that medical science has advanced as it has. And it is most encouraging that public authorities are coming to recognize that there must be created and maintained highly competent official agencies with adequate resources to apply to the public welfare the facts and truths that have been discovered by medical science and whose applicability has been demonstrated by the medical profession. And in my judgment the agency that brings this possibility to a focus and accomplishes results is the public health nurse.

To my mind one of the greatest events that has taken place in this country was that to which allusion has been made more than once this afternoon. That was the establishment in 1893 of the Henry Street Settlement. I wish to add my tribute to what Miss Wald accomplished there not simply as a contribution to New York City but to the entire country and to the world.* From that beginning has grown this great movement which we are celebrating.

Miss Fox in her remarks at this Jubilee luncheon,** and particularly in her closing words pointing toward the future, emphasized the necessity of the adequate preparation of the public health nurse and the production of a much larger number of them. The problem today in the whole public health field in my judgment is the lack of adequate personnel, and I refer to medical personnel as well as to the trained official and the public health nurse. There are communities today ready to take steps and there are not competent people to staff the effort. Further, with the development of the Social Security Act and its application in the future throughout the country, this need will become greater and more obvious. There has been a tendency to think that any person who has gone through a certain basic course—whether in medicine, or in the case of a nurse, one who has gone through a nursing school and has acquired those magical letters "R.N."—is entirely adequate, entirely competent to take up this line of activity.

The public health nurse to be successful demands qualities that are called for by no other group in the nursing field. The bedside nurse of course must be competent, but the task of the public health nurse calls not only for the training of a registered nurse but for something more. In my judgment we cannot do without nurses of the highest quality and the highest training in this public health field. I would like to see more and more college women coming into the nursing schools, passing through them, taking up postgraduate work, and specializing in the public health field.

Now is it any wonder that, having come through these long years of watching and deep interest in the application of knowledge to the different fields of public health, I welcome the opportunity of paying my tribute to what the public health nurse has done and to what the National Organization for Public Health Nursing has accomplished in leading the way and demonstrating the possibilities? That this organization is needed is beyond all question. That it will develop and grow is equally certain and necessary. My congratulations are to the N.O.P.H.N. for what it has already accomplished and I bid it Godspeed for the future.

*Wald, Lillian D. The House on Henry Street. Henry Holt and Company, Chicago, 1915.

**Fox, Elizabeth. "The Past Challenges the Future." Page 275 of this issue.

The Past Challenges the Future

By ELIZABETH G. FOX, R.N.
Executive Director, Visiting Nurse Association, New Haven, Connecticut

Rich in living memories of the history of public health nursing and stirring in its challenge to the future is this address given at the N.O.P.H.N. Silver Jubilee luncheon by a founder and past president of the N.O.P.H.N.

I REMEMBER well that meeting of the American Nurses' Association in Chicago twenty-five years ago—those hot June afternoons when that little band of crusaders representing something like twenty-five hundred public health nurses who were then in existence in the country met together to give birth to the N.O.P.H.N. Among them were, first of all Ella Phillips Crandall—that human dynamo—and Mary Beard, Mary Lent, Edna Foley, Minnie Patterson, Matilda Johnson, Lystra Gretter, Anne Hansen, to mention only a few.* Perhaps some of you who were there will remember, as I do, Mary Gardner standing for hours on the platform working her way through the constitution and by-laws, most patiently but also most humorously.

And perhaps you will remember the prayerful attention that was given to the article on membership, because we were taking a very radical and unprecedented and daring step in inviting the laity, the members of our boards, to join with the profession in working for a common cause. I remember the caution with which that article was written and how we circumscribed these members. We wouldn't give them any office and we gave them only half a vote, so to speak. And I remember how the A.N.A. members, meeting in the other room, were rather scandalized at what these radical youngsters were doing, and they weren't quite certain whether to recognize this mongrel child that we were giving birth to. It was Jane Delano, regal and white-haired as she was, who succeeded in persuading the A.N.A. we were safe, and who came in to give us their blessing.

The next recollection I have is the first annual meeting of that young organization at Atlantic City.* Those of you who were there will recall Miss Wald giving her presidential address. Dressed all in white, she makes me think as I look back, of the Angel Michael, as she stood there and shared with us her compassion, that great compassion, for suffering mankind. And she also shared with us her supreme faith in the power of public health nursing to ease that suffering. I recall the rapt silence with which we all listened, and the sense of exaltation which we all had when the meeting was over. And I think many a young nurse there shared with me that first great sense of dedication to a cause that is greater than ourselves. Such is the power of the word when fed by the passion of an inner flame—which is Lillian Wald.

It was at that meeting that Dr.

*See page 279 for "Who's Who" regarding nursing leaders mentioned in this article.

Address given at the Silver Jubilee luncheon of the National Organization for Public Health Nursing, at the Hotel Roosevelt, New York, N. Y., March 18, 1937.

*The first annual meeting of the N.O.P.H.N. was held at Atlantic City, New Jersey, June 23-25, 1913.

Frankel* gave us our first boost by saying in public and before all the group how important he thought public health nursing was. And while many men have helped us in the N.O.P.H.N. since those days—Dr. Farrand* and many others—no one has given the tremendous support and help of Dr. Frankel.

I can't resist referring to one memory which came to me as Lavinia Dock's letter was read at this Jubilee luncheon. I was going along to the office of the N.O.P.H.N., a single room in which dear Miss Crandall and Yssabella Waters were holding forth, and down the staircase came a very determined little lady with a hat on one side and a large yellow ribbon across her front on which there were large letters, "Votes for Women." That most dear, courageous, grand old warrior, Lavinia Dock!

"STAY AT HOME"

I skip four or five years to the war. That was the first great test, I think, of the N.O.P.H.N. "The office," which was then Miss Crandall and Miss Lent, was moved down to Washington. Miss Crandall was on innumerable committees of the Council of National Defense. Mary Beard was our president at that time. And Mary Beard and Mary Gardner and Ella Phillips Crandall were three people who kept their heads in the midst of all that hysteria. They knew that with so many nurses going abroad—and of course the call of the Red Cross had brought enthusiastic response and the nurses were enlisting by the hundreds and thousands—we must have a second and third line of defense at home, and that we must keep the public health nurses here since the country was becoming so rapidly depleted. They went with that conviction to Miss Delano, and be it said to her everlasting credit that Miss Delano—in spite of the fact that she was under orders to have 100 nurses a day ready for embarkation—saw the point and sent out a letter over her own signature telling the public health nurses that it was their greatest patriotic duty to stay at home.

I don't think we have ever really appreciated the sacrifice that those nurses made in staying behind while all the others went. But it was only a few months later that we were very thankful they had stayed, because you remember what happened. That hideous nightmare—the influenza epidemic—swept down on our country from the Atlantic to the Pacific Coast within three weeks. Telegrams came into the Red Cross by the hundreds from towns and cities all over the United States, begging for doctors and nurses. And we had none to send because every place needed the few that they had left.

It was then that the N.O.P.H.N., joining hands with the Red Cross, entered a concerted plan to make every little public health nursing agency in the country into an emergency organization. And around those little nuclei of two or three nurses, and other nurses who had long since retired, and the married nurses, was built up a corps of volunteers. Sometimes there were ten and twenty volunteers working under one nurse. You remember how houses, churches and halls were turned into hospitals. That group fought day and night, nurse and volunteer together. And again one has to think of their superb courage, for a good many of them laid down their lives—not only the nurses, for it is their tradition to meet an emergency, but the volunteers as well.

Then the war was over and the "flu" was over. The country had learned to appreciate public health nursing. The nurses came back from Europe by the hundreds and thousands and wanted to do something worth while, and we entered that era of tremendous expansion

*Dr. Lee K. Frankel, deceased, was Sixth Vice President, Metropolitan Life Insurance Company; Dr. Livingston Farrand is President of Cornell University.

when public health nursing services sprang up all over the country. In the Red Cross we saw a hundred rural services expand into eighteen hundred within the course of less than two years.

You can imagine what the demands were on our national organization while this tremendous period of expansion was going on. There were demands to help with organization; there were demands to set standards; to help state boards of health develop bureaus of public health nursing. Calls came in from the universities to help them develop courses in public health nursing. Those were the days when Anne Strong made her brilliant contribution to the education of nurses.

ELIZABETH G. FOX

NEW TOOLS FOR WORK

Then came the era of consolidation, an era we are much more familiar with because it is more recent, when all those tools—the census, statistics, records, library, and manual, and all the various guides—were developed. It was about that time, too, that the magazine came to us from Cleveland, the magazine that was born in the mind of Isabel Lowman and Annie Brainard and Josephine Smith and developed in Cleveland, and then came to us in New York. And for many years we had that inimitable editor, Ada Carr.

I am going to pass over recent years because we know them so well. We know how the National Organization has been the center and the stabilizer through these years when FERA and WPA and PWA and Social Security came along one after the other. All of them needed to have public health nursing interpreted to them and we needed very much to have them interpreted to us, and the N.O.P.H.N. stood in the middle trying to do this ambidextrous trick and keep us all satisfied.

Well, that is no kind of a sketch of what lies behind us. I have only spoken of it, not because it was full of glory, though it certainly was and there are so many names of valiant souls one could mention, but just to remind us that the torch has come down through these twenty-five years from hand to hand—I must say smoking badly sometimes, but there was always somebody ready to fan it into flame—and now that torch comes to us. Carry it on into the next twenty-five years! The romance is not all in the past. I think there is just as much adventure ahead of us as there has been in those glorious twenty-five years that lie behind.

I am not going to describe the changing battlefield, the new enemies that we have to fight, the new weapons that we have to fight with, the expansion in our public health nursing program, the increase in demands upon us. I merely want to mention some of the responsibilities that these changes place upon our shoulders as we go forward into the next quarter-century.

One of these responsibilities is to see that all this new and very potent knowledge that we have been receiving in the last few years is put into wider use. We

have 20,000 public health nurses in the country. We ought to have 60,000 at least. Our rural areas haven't anything like the amount of public health nursing that our cities have, and our cities haven't anything like the amount of public health nursing that they ought to have. When the American Public Health Association doesn't dare to set its standard for prenatal nursing higher than that we should reach 15 percent of the expectant mothers, you can see just how inadequate public health nursing still is. I should like to see this twenty-fifth birthday memorialized by abandoning the old ratio of one nurse to two thousand people. That day is passed. Let's go forward into the next quarter-century with a better ratio than that.

CAPACITY FOR SOCIAL ACTION

If we are going to have a wider use of the nurse geographically, and in relation to the proportion of people in the cities who need her, and in relation to the economic groups (we are still not doing much better than taking care of the poor), it means that we have to have money. Some of that money is certainly coming to us through the splendid expansion of public health nursing under the government. And that is a situation which calls for confidence and active support on our part if the government is going to be able to set standards and maintain standards such as we all want to see. I am inclined to think that this is the acid test of our sincerity and of our capacity for social action. And then I am perfectly certain that more money will come from the people if we can succeed in making our own concern for humanity contagious and if we can give to those who have money to spare, confidence that our feet are on the ground in all that we are doing.

If, then, we are to have wider use of our service and the money to do it with, what does that demand of our organizations?

In the first place, we must have superior nurses. There has been a great increase in our knowledge in the biological, the sociological, the psychological, and the educational fields, in medicine, in preventive medicine, and in public health. Our nurses must be armed to the fullest extent with this knowledge, and in addition to that they must have the artistry of those who have gone before—for I think we can scarcely hope to produce more superb bedside nurses than some of those I knew twenty-five and thirty years ago.

If we are to have superior nurses and if we are to see this army of young people—well trained, idealistic, anxious to do their best, anxious to grow—if we are to see them develop their full potentialities, we must get a very much broader conception of supervision and we must not be so niggardly in our supply of supervisors. At present we are all too often giving this young group who are the hope of the future not much more than the cold ashes of routine. Until we get a broader conception, they will have little chance to develop to their fullest.

And if one is going to speak of the need for superior nurses and superior supervisors, then I am afraid we shall have to have superior administrators. There is so much that we administrators could say about our shortcomings, so much more that we know we must have as the job grows more complex, more costly, more intricate in relationships, more deep and rich.

Then who comes next that must be superior? Some of you, I know, have guessed. We must have superior boards. We must have boards who realize that we are engaged in a great and serious public service—not in a small pet charity. We must have boards who are serious students of social science, of social statesmanship, of social planning. We must have boards who know their purpose and their functions and their

responsibilities and are as superior in their area of competence as we are fully determined that we are going to be superior in our area of competence.

And then behind us all there must stand a strong, national organization. And the N.O.P.H.N. and the nurses and the boards together must have the faith and the courage and the wisdom and the humor and the imagination, the devotion and determination of those who have gone before us.

The past, I think, gives us ample confidence to face the future, confidence that the National Organization will not let us down, confidence that we will not let the National Organization down, and confidence that together we will not let down the people who are looking to us for life and health.

WHO'S WHO IN THIS ARTICLE

ELLA PHILLIPS CRANDALL: First Executive Secretary of the N.O.P.H.N., 1912-1921. Member in 1912 of editorial staff, *The Visiting Nurse Quarterly* (which became *The Public Health Nurse* in 1919, PUBLIC HEALTH NURSING in 1932). Instructor, Department of Nursing and Health, Teachers College, Columbia University, 1912. Now Secretary of the Payne Fund, New York, N. Y.

MARY BEARD: President of the N.O.P.H.N., 1916-1919. Member of the first Board of Directors and Life Member of the N.O.P.H.N. Author of *The Nurse in Public Health*. Now Associate Director, International Health Division, Rockefeller Foundation, New York, N. Y.

MARY E. LENT: First Treasurer of the N.O.P.H.N. and Associate Executive Director, 1916-1921. Member editorial board, *The Public Health Nurse*, during its early years. General Supervisor of Public Health Nurses, U. S. Public Health Service, 1917-1919. Now has an antique shop in Wallington, N. Y.

EDNA FOLEY: Chairman of the committee which called the meeting to organize the N.O.P.H.N. Member editorial staff, *The Visiting Nurse Quarterly*, in 1912. First Vice-President of the N.O.P.H.N., and President, 1920-1921. Superintendent, The Visiting Nurse Association, Chicago, Ill., 1912-1937.

MINNIE PATERSON: Member of first Board of Directors of the N.O.P.H.N. Member of the N.O.P.H.N. from 1912 till the present time. Superintendent, The Visiting Nurse Association, Minneapolis, Minn., 1907-1920. Now engaged in school nursing in Aberdeen, Wash.

MATILDA JOHNSON: Member of first Board of Directors of the N.O.P.H.N. Superintendent, The Visiting Nurse Association, Cleveland, Ohio, 1904-1914. Member of the editorial staff of *The Visiting Nurse Quarterly* in 1912. Supervisor and later superintendent of nursing, Metropolitan Life Insurance Company, 1914-1931. Retired and living in Evanston, Ill.

LYSTRA E. GRETTER: Member of the N.O.P.H.N. from 1912 until the present time. Superintendent, Visiting Nurse Association, Detroit, Mich., 1907-1923, and member board of trustees from 1923 till present time.

ANNE L. HANSEN: Member of first Board of Directors of the N.O.P.H.N. and a board member at the present time. President of the N.O.P.H.N., 1926-1930. Director of the Visiting Nurse Association, Buffalo, N. Y., from 1911 till the present time.

MARY S. GARDNER: Secretary of the joint committee appointed to consider a national public health nursing organization, and member of first Board of Directors. President of the N.O.P.H.N., 1913-1916, honorary president since 1922, and Life Member. Director, District Nursing Association, Providence, R. I., 1905-1931. Awarded Saunders medal in 1931. Author of *Public Health Nursing*, now in its third edition.

JANE DELANO: Member of first Board of Directors of the N.O.P.H.N. President, American Nurses' Association, 1909-1911. Chairman, Nursing Service, and later Director, Department of Nursing, American Red Cross, 1909-1919. Died while in overseas service in 1919.

LILLIAN D. WALD: First President of the N.O.P.H.N., 1912-1913; Honorary President and Life Member of the organization. Founder of Henry Street Settlement and the Henry Street Visiting Nurse Service. Pioneer and leader in social and health movements too numerous to mention here. Author of *The House on Henry Street* and *Windows on Henry Street*. Retired and living in Westport, Conn.

LAVINIA L. DOCK: A pioneer public health nurse, who served with the New York City Mission, the first organization in the United States to provide visiting nursing care for the sick poor. Worked with Miss Wald at Henry Street Settlement. Secretary, International Council of Nurses, for many years. Prolific writer of nursing articles and books; collaborator of *History of Nursing*, with Adelaide Nutting. Retired and living in Fayetteville, Pa.

YSSABELLA G. WATERS: First chairman of eligibility and first statistician of the N.O.P.H.N. Gave voluntary service to the N.O.P.H.N. from 1912 to 1921 and made the first census of public health nurses in the United States as a voluntary project. From 1899-1913, in charge of clubs and general social work, Henry Street Settlement. Retired and living in Groton, Mass.

ANNE STRONG: Director of School of Public Health Nursing, Simmons College, Boston, Mass., 1918-1925. (Assistant Professor, 1916-1918.) Lecturer at Teachers College, Columbia University, leader, counsellor, and wise guide of many students. Consultant to the Committee for the Study of Nursing Education, appointed by the Rockefeller Foundation, whose report, *Nursing and Nursing Education in the United States*, was published in 1923. Died in 1925.

ISABEL W. LOWMAN: Lay member of the N.O.P.H.N., beginning 1912. Member of board of trustees of The Cleveland Visiting Nurse Association in 1912 and at the present time. First editor of *The Visiting Nurse Quarterly*. Living in Cleveland, Ohio.

ANNIE BRAINARD: Editor, *The Public Health Nurse* (formerly *The Visiting Nurse Quarterly*), 1909-1923. President, The Visiting Nurse Association, Cleveland, 1913. Author of *Organization for Public Health Nursing*, *The Evolution of Public Health Nursing*. Living in Cleveland, Ohio.

M. JOSEPHINE SMITH: Managing editor, *The Public Health Nurse*, 1914-1923. Lay member of the N.O.P.H.N. from 1916 till the present. Executive Secretary, Central Committee on Nursing, Cleveland, Ohio, from 1914 till the present time.

ADA M. CARR: Editor, *The Public Health Nurse* (later PUBLIC HEALTH NURSING), from 1924-1930. Member of N.O.P.H.N. beginning in 1913. Now retired and living in Catonsville, Md.

A Curative Workshop for the Crippled

By LAURA A. DRAPER, R.N.
Director, Community Health Service, Minneapolis, Minnesota

Twinkle, twinkle, little star,
How I wonder what you are.

THE VICTROLA is reiterating the old nursery rhyme, a little hoarsely after innumerable repetitions. To the listening children, however, it has the charm of familiarity. They stretch their arms and point their toes joyfully, and with as much vigor as their varying handicaps permit. Each has a physical disability. Bobby is suffering from after-effects of encephalitis, Jane from torticollis, John, Ellen, and Sven from spastic paralysis.

They are a few of the crippled children of Minneapolis gathered at the Curative Workshop for treatments. It is here in a building in the central part of the city that much of the physiotherapy and occupational therapy of the Community Health Service is done.

CENTER FOR TREATMENT

The shop was opened in 1931. Prior to that time the program had been entirely one of home service. It had become evident, however, that many patients could come to an office for treatment, and that under such a plan a greater number could be treated, and the treatment rendered more effectively. Convinced of this, the Citizens Aid Society of Minneapolis made possible the equipping of the shop.

Space which had formerly housed a double store was selected. It was partitioned into a waiting room, treatment room, small gymnasium, occupational-therapy room, and a minimum of desk space. Curtains divide the treatment room into cubicles where the workers give massage and passive exercises, lamp treatments, baking, and wax treatments. A Hubbard tank assists patients in voluntary exercises. Wall bars, rings, and stairs are available in the gymnasium, where also it is possible to exercise arms and legs by means of throwing games, push-mobile and tricycle. Looms, saws, and workbench are intensively used in the occupational therapy department.

STAFF OF WORKSHOP

The staff of the shop is composed of a physiotherapist-director, five other nurse-physiotherapists, three graduates of recognized schools of occupational therapy, a clerk, and a driver for the patients' car. The director had physiotherapy training in England, two others have had the year's course at Harvard, and two more the year's course at Northwestern University. The sixth worker is a public health nurse from the Community Health Service staff, having physiotherapy experience. There is no question in the minds of any of us that public health nursing background is an asset, particularly in the work in homes. To add to a nurse's preparation a course in public health nursing and a course in physiotherapy is, however, an expensive procedure. It is not surprising that comparatively few nurses have compassed it, and that for the country at large the supply does not meet the demand.

Since the workers at the shop are a part of the Community Health Service staff and attend staff meetings and station conferences with our special consultants, and since the shop director is one of our supervisory group, we have a community of interests and a pooling

of experience which is helpful to all of us.

The patients' car represents a means of transportation for patients. Since many of the patients are so crippled as to be unable to use the streetcar, and since many families are unable to secure automobile transportation, it was evident that if the shop was to be fully used we would have to find some means of carrying the patients back and forth. The driver works on a regular schedule, arriving at the shop with the first group of children soon after eight-thirty, going out again for the next group, and picking up the first group when he arrives with the second. His days are very full; if the home-going children are not ready he busies himself helping the waiting group out of their wraps, and assisting the volunteer in starting them on some group activity. We feel, incidentally, that this is one of the definite assets of the shop—the opportunity which it gives handicapped children to learn to play with others.

VOLUNTEERS AND COMMITTEES

We would be greatly handicapped in our work were it not for the very generous service given by volunteers. Each morning one or more is on duty to help wherever she is most needed. This may mean staying with a child who is under a baker, assisting a second to walk up and down steps, encouraging a third in his use of a tricycle. It includes posting records, presiding at the sand-box, sorting laundry, and a dozen other activities. A great deal of time is contributed also by members of the Curative Workshop Board. A list of the committees indicates something of the diversity of their work. They are:

Nurses and Aides Committee
House Committee
Volunteers Committee
Buying Committee
Sales Committee
Social Committee
Clothing and Shoe Committee
Library Committee
Publicity Committee
Finishing Committee
Nominating and Membership Committee
Transportation Committee

REFERRAL OF PATIENTS

Our patients come to us from various sources. Some report themselves. We have been pleased by the fact that a number recently have been referred by private physicians; others have come through insurance companies. Since about 4500 preschool children are registered at the Community Health Service infant and preschool clinics, it is natural that a number are sent by the clinic doctors. Community Health Service nurses find others in homes. The Minneapolis General Hospital gives physiotherapy to patients while they are in the hospital, but upon discharge refers them to us. Our County Sanatorium directs certain of its patients with arrested tuberculosis to the shop upon discharge.

The Minneapolis public school system has one school where disabled children are taught up to high-school level. Treatment is given these children while at school, but during vacations many come to us. Upon graduation from this special school unit, the children may attend high school; and as no treatment is given there, those needing our service come to the shop after school.

Gillette State Hospital* and the Shriner's Hospital for Crippled Children refer to us their postoperative Minneapolis cases needing treatment. Through Social Security funds the State Division of Services for Crippled Children is arranging hospitalization in private hospitals in order to decrease the waiting lists for the state hospitals. We have been asked to supply treatment in the hospitals when ordered, since most of the private hospitals do not have physiotherapy workers.

The shop registration includes children and adults, the latter at present outnumbering the former. Of the fifty-

*State hospital for crippled children.

two patients under seventeen years of age, 34 percent have spastic paralysis, 8 percent have fractures, more than 5 percent congenital deformities. There is only one case of poliomyelitis. Minneapolis has been fortunate in regard to this disease in recent years.

Physiotherapy and occupational therapy treatments are given in homes as well as at the shop, but home cases are transferred to the shop as soon as the physicians think practicable. Needless to say, patients are carried only under a doctor's direction.

Support of the shop is largely from the Community Fund, with a contribution of approximately $2500 from the Junior League. About $400 is earned in sales, and last year $2442 came from payment for services. Our full fee for treatments is $2. Many families pay nothing and many others only a part of the cost.

The majority of patients are of a type whose progress is necessarily slow. Red letter days come, however, when Jimmy for the first time lifts his paralyzed arm above his head, or when another child understands Ellen's speech. The worker must not only give expert care, but by her understanding, patience and optimism, encourage the patient and parents to persevere.

NOTE: The next in this series of articles on programs for crippled children will appear in the June issue.

INDUSTRIAL NURSING CONFERENCE

A spirited discussion of ways in which industrial nurses can improve their service took place at an Industrial Nursing Conference sponsored by the Employers Mutuals of Wausau, Wisconsin, held in Milwaukee, Wisconsin, on March 19. The nurses who give service to policyholders of Employers Mutuals were invited, and there was a 98 percent attendance of those invited—due to the fact that the company wrote directly to the employer as well as to the nurses.

F. W. Braun, manager of the Safety Engineering Department, spoke on the nurse's influence in accident prevention. He stressed the importance of a close coördination between the industrial nurse and the safety committee in industry, to aid in preventing accidents which occur frequently because of thoughtlessness of employees. He emphasized that a knowledge of the product manufactured in the plant is a requisite for effective industrial nursing service.

Adda Eldredge, Director of the Nurse Placement Service in Chicago, discussed the future of industrial nursing. She emphasized the need for a knowledge of public health work in order to do intelligent industrial nursing, and said the future holds great opportunities for the well trained nurse in the industrial field.

A knowledge of how accidents affect compensation rates gives the nurse additional reasons for aiding her employer in the control of this important item of cost, according to W. H. Burhop, Vice-President of Employers Mutuals, who addressed the group on the relation between accidents and compensation insurance rates.

The evening dinner was attended by a hundred people, including nurses, insurance adjusters, safety engineers, and officials from the company. Dr. James C. Sargent, President-Elect of the Wisconsin Medical Society, was the guest speaker. He brought out the need for closer contact between the industrial health service and the private physician.

SALARY STUDY

The results of the N.O.P.H.N. study of salaries of public health nurses which appears annually in the May number, were not available in time for publication in this issue of the magazine. The 1937 report will appear in June.

Is Our Home Nursing Care of Communicable Disease Adequate?

By ALMA C. HAUPT, R.N.
Director of Nursing Bureau, Metropolitan Life Insurance Company

The importance of extending the nursing facilities for bedside care and supervision of communicable disease patients in the home is forcefully brought out in this discussion of some of the problems and limitations in our present program for communicable disease control

THE prevention, control, and care of communicable diseases is admittedly one of the major health problems confronting health workers and the public today. It calls for the most skillful and complete coöperation between the medical profession, health officers, school physicians and teachers, nurses, hospitals, and laymen. If all of us work together on a plan, there is no reason why we cannot meet this urgent need in the public health movement, which up to the present has been largely passed by.

If we consider the number of deaths and the estimated number of cases from the four common communicable diseases of childhood, we are faced with the seriousness of our task. According to the mortality reports of the Bureau of the Census, the number of deaths in the United States in one year (1934) was:

Diphtheria	4159
Scarlet fever	2524
Whooping cough	7518
Measles	6986
Combined total	21,187

It is estimated that this number of deaths represents 3,000,000 cases of sickness. But that is not the whole story. We must add the aftermath of heart disease, tuberculosis, blindness, deafness, and other sequelæ. We are dealing often with very sick children and those who may suffer serious consequences for years.

On a recent field trip across the country, I asked some twenty city health officers if public health nursing is important in communicable disease service. There was unanimous and emphatic assertion that it is not only important but essential, although as yet we seem not to have developed statistical means of proving it in figures. We have, however, a strong statement based on facts in a survey of communicable disease hospital needs in one of the boroughs of New York City:

> The outcome of these diseases, especially in infants and children of preschool age, is more likely to be favorable under good home care than it is in the hospital. . . . When home quarantine is not possible hospital care becomes mandatory; when conditions for home care are unsatisfactory, or when the infection is unusually severe, or when complications, especially of a surgical nature arise, hospital care offers the better prospect.
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> [Among the conclusions are:] The home care of acute communicable disease utilizing competent, organized visiting nurse services, demonstrates an effective and economical method for the control and care of contagion. The

Presented before the Health Officers and Public Health Nursing Sections and American Association of School Physicians, Annual Meeting, American Public Health Association, New Orleans, Louisiana, October 22, 1936. Published in the *American Journal of Public Health*, May 1937.

adoption by the city of the policy of home nursing care for suitable cases, in addition to hospital care, should result in material improvement in the control of contagion within the home and in lowered mortality.[1]

Granting that public health nursing is essential in combating a major health hazard, let us see to what extent it is meeting the problem. Table I shows the number of communicable disease cases and visits reported by 84 cities in The City Health Conservation Contest* of 1935. It should be understood that some of these visits were made by physicians, although the majority were made by public health nurses. But few of these visits were concerned with bedside care. They were the usual inspection and instruction visits made to effect quarantine and to avoid the spread of disease.

TABLE I. COMMUNICABLE DISEASES

Number of cases and visits reported by 84 cities City Health Conservation Contest—1935

Disease	Cases	Visits
Diphtheria	2,968	26,964
Scarlet fever	36,429	178,013
Whooping cough	31,557	81,472
Measles	146,398	344,893
Total	217,352	631,342

From Table I we are able to get the average number of visits per case as reported in the City Health Conservation Contest.** As these figures are for the most part visits by health department nurses who do not give bedside care, it is of interest to compare them with corresponding figures of the Metropolitan Life Insurance Company nursing service, which is chiefly a bedside-care service. This comparison is made in Table II.

TABLE II. COMMUNICABLE DISEASES

Disease	Average visits per case: City Health Conservation Contest—84 cities	Average visits per case: Metropolitan Life Insurance Company nursing service
Diphtheria	9.1	6.4
Scarlet fever	4.9	8.3
Whooping cough	2.6	4.9
Measles	2.4	4.6

As might be expected, the number of visits per case is higher when bedside care is included, with the exception of diphtheria, many cases of which are cared for in hospitals.

Is the number of visits reported in the City Health Conservation Contest adequate? The number of visits should probably be twice as many, if bedside service is included, judging by the experience of the Metropolitan Life Insurance Company nursing service in this field, as presented in the above table.

Another picture showing the extent of skilled nursing care for communicable disease is presented from the mortality records of the Metropolitan Life Insurance Company for 1935. (Table III.) The Company is eager and willing to pay for this service to its acutely ill

*Annual contest under the auspices of the American Public Health Association.

**Unpublished data from American Public Health Association Committee on Administrative Practice.

TABLE III. NURSING COMMUNICABLE DISEASES

Percent of fatal cases reported for nursing to Metropolitan Life Insurance Company visiting nurse service—1935

Disease	Deaths of Metropolitan policyholders in communities with Metropolitan visiting nurse service	Reported to Metropolitan visiting nurse service: Number	Reported to Metropolitan visiting nurse service: Percent	Died in hospital: Number
Diphtheria	269	36	13	31
Scarlet fever	322	54	17	41
Whooping cough	321	81	25	31
Measles	301	64	21	44
Combined	1,213	235	19	147 or 12%

policyholders, either through its affiliation with visiting nurse associations or through its own nurses.

An analysis of the Company's mortality records for communities in the United States (excluding the Pacific Coast Territory), in which Metropolitan nursing service was available is given in Table III. (See page 284.)

An analysis of the deaths from diphtheria, scarlet fever, whooping cough, and measles among Metropolitan policyholders during 1935 shows that only 19 percent of these patients had received care through the Metropolitan nursing service; whereas 81 percent had not received such care. We do not know what other nurses were visiting these cases, but it is reasonable to suppose that they were health department or school nurses who do not give actual nursing care. However, of the total number, hospitals gave care to 12 percent. Potentially, then, we are failing to provide bedside care to eight out of ten children who die of communicable diseases. In the general population, I fear that the nursing facilities of the community fail to reach even a larger percentage of sick children.

At the present time, acute communicable diseases of childhood account for 8 percent of the nursing case load of the Metropolitan Life Insurance Company, but in view of the mortality record and what is generally known about morbidity, this is still far below what it should be.

At this point we should consider what the function of the public health nurse is in communicable disease service. This is summarized under five headings:[2]

1. Case finding, which includes the promotion of reporting, and assistance in getting medical attention for diagnosis and treatment.

2. Giving or securing and supervising home-nursing care for the carrying out of orders of private physicians and of health departments or other agencies.

3. Instructions to individuals, families, and the community regarding quarantine, isolation, nursing care, preventive measures, use of community facilities and the importance of the whole communicable disease problem.

4. Promotion of immunization programs among infants, preschool children, and others in accordance with health department policies.

5. Assistance in making studies of epidemiology, the behavior of disease in a given community, and results of nursing service.

In this discussion we are concerned

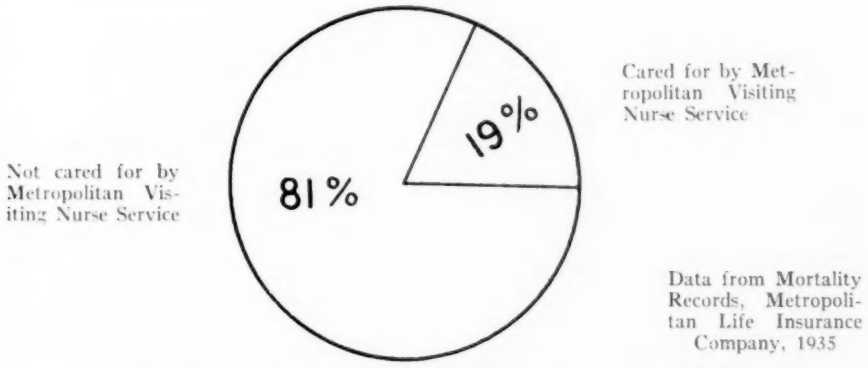

Chart showing analysis of deaths from diphtheria, scarlet fever, whooping cough, and measles of Metropolitan policyholders in 1935, according to whether they received care from Metropolitan nursing service

with all of these phases of public health nursing service rather than with any one phase.

The experience of one nurse during a busy winter day illustrates very vividly how the public health nurse fulfills these functions.

I recall a nurse who started out in the morning making a kindergarten inspection. Little Johnny turned up with a sore throat. She sent him home immediately sending word to his mother to call a doctor. The doctor diagnosed the case as scarlet fever. Later on this same morning she went into a home where a youngster had been in bed for several days with scarlet fever. The mother, in a four-room apartment, was carrying out perfect isolation technique. The nurse had traced the source of infection of this child, and learning that other children had been playing with him at the time of exposure, she had warned the other mothers to watch for symptoms such as a sore throat and feeling of malaise, to put the child to bed if such occurred, and to call a doctor.

As she was leaving this home the nurse met some relatives who were coming to call. She took the opportunity to explain to them what the placard meant, what she was doing for the child, and how the mother was carrying out isolation. She stressed the importance of keeping their children away from crowds during that season of the year. She explained that there were some diseases for which specific vaccines existed so that the diseases could probably be prevented. She referred specifically to smallpox and diphtheria. Incidentally, later on she discovered that these mothers, impressed with the illness of the child in the home they were about to visit, took their children to the physician for toxoid.

Finally that same day, the nurse while passing another home was called, from a window, by a poverty-stricken mother, frantic because her Tony had a fever. The symptoms indicated a communicable disease. The family could not afford a private physician so the nurse called the department of health, reporting the symptoms. The next morning Tony was taken to the isolation hospital—another case of scarlet fever under care.

After this busy day, the nurse, returning to her office, made out a special report of the visits made to communicable diseases. This was her share in the statistical study being made by the health department, of the nurse's part in communicable disease control.

FUNCTION OF THE NURSE

Communicable diseases take a terrific toll in human lives, human comfort, and human safety. They can, in certain instances, be wiped out; in other instances, greatly reduced. The public health nurse is a tremendous force in accomplishing eradication and control. There are 20,000 public health nurses in the country. Why do we not use all of them, whether they be employed by health departments, schools, industries, or visiting nurse associations, to do this job more completely and more successfully?

The answer is that we are beset with obstacles which we have allowed to block our path. The first of these is poor reporting of cases—a constant problem for health departments, physicians, schools, industries, and nurses. Here is one of the nurse's first responsibilities—she should not and does not diagnose but she can suspect. While not a diagnostician, she can be a top-notch "suspectician." Immediately she has the opportunity to direct families to proper medical service. We should count more and more on the nurse, whether employed by health departments, schools, industries, or private agencies to be more active in case finding and case reporting.

As soon as a case is found, diagnosed, and properly reported, the next problem for the nurse is to provide needed nursing service. We face immediately the question: Is placarding and instruction enough, or does the mother need help in actual nursing and continuous advice? By and large, health department nurses and school nurses do not give bedside care. This means that where such care is needed, the patient must be transferred to an organization giving bedside care such as a visiting nurse association. Hence, we are dependent on a very fine appreciation on the part of official-agency nurses as to the value of bedside care, and their active coöperation in turning cases over to the bedside nurse.

Is there a well established plan of transferral in most communities? I fear not. Is the visiting nurse equipped not only to give bedside care but also to carry out the same instructions as given by the health department and then to transfer the case back to the health department for necessary termination? One problem here is that some health departments, legally responsible for communicable disease cases, feel that their nurses must visit regardless of what other agencies are also sending in nurses. A solution might be that health departments legally deputize the local visiting nurse agencies to carry communicable disease cases during the period when bedside care is necessary.

COÖRDINATION VITAL

All of this points to the fact so well brought out in the *Survey of Public Health Nursing*[3], made by the National Organization for Public Health Nursing, that we are confused by too many local agencies engaged in public health nursing service. Hence, the recommendation of the Survey that we should try to condense our service locally into not more than two agencies, one the official for health supervision and communicable disease control, the other a private agency giving bedside care as part of a family health service. In small communities, all of these functions may well be carried by one agency.

Health department approval for the giving of communicable disease nursing on the part of visiting nurse associations and Metropolitan nurses is a necessary prerequisite to the service. In 335 Metropolitan Life Insurance Company services, we find that 82 percent have such approval, 7 percent have it for certain towns in the area but not for all, 11 percent have no approval. This is a definite handicap to the service and one that indicates lack of understanding on the part of some health officers.

Some of the blame for our errors in communicable disease nursing lies at the door of the very person we are talking about—the nurse herself. Two factors may lead to her own hesitancy to do communicable disease nursing: the limitation of her preparation in this field, and a sense of fear due to her own lack of immunization. In *Nursing Schools, Today and Tomorrow*,[4] it is stated that of the students who graduated in 1932, nine out of every ten had less than two months' training in communicable disease nursing. In the handbook *Some Facts About Nursing*[5] we find that in January 1935, in a study of 1311 schools of nursing, less than three-fifths of the schools provided experience in communicable disease care.

In a recent study of 177 Metropolitan Life Insurance Company salaried nurses, it was found that only 60 percent had communicable disease nursing experience during their hospital training. To make up for this, 92 percent of this group have been given practical demonstrations by Metropolitan Life Insurance Company supervisors and all have received study programs and written instructions. Undoubtedly, one point of attack is the school of nursing, which should include both theory and practice in the basic curriculum. For

the 20,000 nurses now employed in public health nursing, postgraduate work, institutes, and demonstrations are greatly needed. The excellent *Manual of Communicable Diseases for Public Health Nurses*[6] published by the New York State Department of Health might profitably be used by every public health nurse in the country.

The immunization of the nurse is also a factor. The National Organization for Public Health Nursing advises that nurses be immunized against smallpox, typhoid fever, and diphtheria before employment and against scarlet fever if the local medical advisory committee approves. In a recent canvass of 150 Metropolitan Life Insurance Company salaried nurses, the percentages immunized were:

Smallpox	99%
Typhoid fever	80%
Diphtheria	53%
Scarlet fever	22%

It would seem that greater attention to the immunization of nurses would encourage their more active participation in the program.

LAY SUPPORT NECESSARY

We have blamed organizations, including medical and nursing groups, for our limitations in communicable disease control; but the layman, too, is at fault. There are some boards of directors which still hold back permission for the staff to do communicable disease nursing. The responsibility comes back to the health officer, medical advisory committee and director of nurses to inform such boards of the importance and safety of such participation under proper supervision, appropriate restriction, and administrative and educational control. We need to win favorable public opinion of board members and of families to the service.

Let's explode the fear that the properly informed nurse may be a carrier of contagion. After all, how often does one hear of a cross-infection being carried by a public health nurse? Why does no one worry about the transmission of disease by a doctor who may touch the patient? And yet the nurse who visits the home, washes her hands before and after her visit, wears a gown, and carries out a scrupulous technique, has been such a source of suspicion. If a nurse is unsafe to do communicable disease nursing, is she not equally unsafe for any other service? When we realize that nurses are dealing constantly with undiagnosed cases in their most infectious stages, it oftentimes seems ridiculous even to go through the precaution of visiting communicable disease cases the last part of the day.

In summarizing and concluding this discussion, I would say that many lives are being sacrificed because we are not making more effective use of all public health nurses. To correct this, five aids are suggested:

1. Better understanding of the whole service of public health nursing in this field, on the part of physicians, health officers, school personnel, industries, and the lay public.

2. Reduction of the number of public health nursing agencies in over-organized communities and a joint plan of procedure and referral of cases between local agencies.

3. Proper preparation of nurses in undergraduate schools, and postgraduate education through institutes, staff education programs, and special courses for all public health nurses.

4. Approval by all health departments of the participation of bedside nursing agencies in the program, and the setting up of standing orders approved by both health departments and medical advisory committees for bedside care in this service.

5. Investigative and promotive activities by all agencies concerning such questions as the volume of service, the results of service, the follow-up of cases hospitalized, the control of secondary cases, and the immunization of all susceptible groups.

What more challenging opportunity is there before public health nursing today than to assist in the control and eradication of diseases that take a heavy toll—especially among children—yet are preventable and curable, and should be curtailed or wiped out?

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[3]National Organization for Public Health Nursing. Survey of Public Health Nursing. The Commonwealth Fund, New York, 1934.

[4]Committee on the Grading of Nursing Schools. Nursing Schools, Today and Tomorrow. Final Report. National League of Nursing Education, 50 West 50 Street, New York, N. Y., 1934.

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A PUBLIC HEALTH NURSING STUDY

A study of nursing care of the sick by public health nursing agencies in the New York Metropolitan area was made by the National Organization for Public Health Nursing in 1936. This study is a part of the general survey of resources for the care of the sick in this area, sponsored by the United Hospital Fund and financed by grants from the Carnegie Corporation, from Mrs. Kate Macy Ladd, from the Josiah Macy Jr. Foundation, and from the Milbank Memorial Fund. The survey includes studies of the facilities, their use, and their cost, in the eight major types of institutional and agency care of the sick in New York and its immediate vicinity. This is a unique contribution toward better program planning and the development of more adequate service. It includes hospital and clinic facilities and resources for the home care of the sick. It has been conducted under a survey committee headed by Dr. George E. Vincent, with David McAlpin Pyle, president of the United Hospital Fund, as vice-chairman. The director for the study is Dr. Haven Emerson, with Dr. Gertrude Sturges acting as his assistant.

The report of this survey will appear early in May under the title, "The Hospital Survey for New York." Chapter XIII of Volume II will tell of the part played by public health nurses. Data for the public health nursing study were obtained from a questionnaire sent to agencies in the area giving nursing care to sick, and employing two or more nurses.

A summary of some recommendations of the study which might well receive consideration outside of the New York Metropolitan area are listed. They suggest:

1. That nursing councils or community nursing committees be organized in each community to consider problems relating to distribution of service and avoidance of duplication, and to plan for future development.

2. That each agency study its own program to determine adequacy of service and to evaluate community needs, in planning to modify or add services.

3. That each agency record for at least a year all requests for service that were not filled and the reason therefor.

4. That efforts be made in each community where duplication of home-nursing care is shown to bring together the various groups so that only one agency will offer nursing care to the sick as a part of a family health service.

5. That programs of public information be instituted by agencies to increase use of service by those able to pay for it.

6. That the appropriate public authorities be asked to pay for services rendered to dependent patients.

7. That charge for service be based on cost per visit and that this charge be maintained at or slightly above cost.

8. That each agency adopt the nomenclature, classification, and definitions of services suggested by the Records Committee of the N.O.P.H.N.

9. That quality of staff and arrangements for supervision in agencies of three or more nurses be brought to a standard that will make possible the offering of student affiliations to schools of nursing.

Encouraging Words from a Friend

ONE of the satisfactions which has come to the officers and members of the National Organization for Public Health Nursing because of the celebration of this Silver Jubilee has been the way in which men and women of distinction in American life have expressed their praise for the Organization's accomplishments. Some of these encouraging comments from friends have been used by us in leaflets designed to win additional support. Others are so good that they should be shared.

To those nurses or lay members in local agencies scattered throughout the United States who are trying in these days to win a larger membership or additional financing for our Jubilee program of public service, such testimonials are useful. A statement which has been received recently at National Headquarters from Dr. Thomas Parran, Jr., Surgeon General of the United States Public Health Service, is one of these. Dr. Parran's endorsement of the N.O.P.H.N. carries weight wherever persons are at all familiar with public health problems. We are quoting it here in full:

"Twenty-five years ago," he writes, "through the vision and enthusiasm of a small group of women, the National Organization for Public Health Nursing came into being. At that time, the work of the nurses was largely confined to visiting the sick under the auspices of private organizations. During the past twenty-five years, no public health activity has increased so rapidly as has public health nursing. No other service has become of greater importance to the successful operation of an official public health program. From 3000 to more than 20,000 members in less than a quarter of a century is truly a remarkable growth for any professional group and proves that the first objective listed in the constitution of the National Organization for Public Health Nursing which was framed at that meeting in Chicago in 1912—'to further the extension of public health nursing'—is being splendidly accomplished.

"Another one of the objectives of the nurses who framed the constitution of the National Organization for Public Health Nursing was to 'further the education of nurses in public health and to develop standards and techniques in public health nursing.' Few professional groups have made the progress which the public health nurses have in defining the qualifications of their members, in establishing definite plans for attaining those requirements, and in analyzing critically their own weaknesses and accomplishments. Credit for this remarkable progress is due to the staff of the National Organization for Public Health Nursing and to the splendid group of public health nurses and lay representatives who make up the membership of that Organization.

"The U. S. Public Health Service has drawn heavily upon the resources of the National Organization for Public Health Nursing in preparing recommendations with regard to the public health nursing developments made possible through Social Security funds. The standards and requirements recommended by the National Organization for Public Health Nursing have guided the state and territorial health officers in the development of their public health nursing programs and they will continue to look to this professional group for guidance and assistance.

"There is an ever-increasing demand for more and better qualified public health nurses. Each year additional health functions are being delegated to the nursing group. Public health nursing is a necessary and integral part of

every health department service. The National Organization for Public Health Nursing must continue to study the needs of public health nurses, to formulate standards and policies which affect this group, and to stimulate the interest of the public in this important phase of public service.

"Public health nurses have accepted their responsibilities with an enthusiasm and a zeal which is the admiration of all of their coworkers. Miss Gardner, Honorary President of the National Organization for Public Health Nursing, expressed this very clearly when she said: 'I know of no more compelling force in the world than a well directed enthusiasm that can expend itself on a worthy cause.'* Surely there is no more worthy cause than the everyday activities of the public health nurse."

In these days of Jubilee for our first twenty-five years of growth, the N.O.P.H.N. takes a natural pride in being able to quote such words as these. It is to be hoped that they may be quoted locally, wherever public nursing services, helped by the National Organization, are keeping up the high standards of the profession and trying to enlarge our public service.

*Mary S. Gardner. "Twenty-five Years Ago." PUBLIC HEALTH NURSING, March 1936.

Paul Parker Photo

At the Silver Jubilee Luncheon of the National Organization for Public Health Nursing in the Roosevelt Hotel, New York City, on March 18, were: (left to right) Dr. Livingston Farrand, President of Cornell University; Henrietta Hoffman, the public health nurse of 1937; Lulu St. Clair, representing the public health nurse of 1912; and Charles C. Burlingham, President of the New York Welfare Council. (See page 326 for an account of the luncheon.)

"Welcoming the Nurse," the new N.O.P.H.N. poster, is described on page 4.

Health Teaching in a Secondary School

By MARY E. BOWEN
Health Teaching Supervisor, School Health Service, Syracuse, N. Y.

How can health education be incorporated in the secondary-school curriculum? The program which has been developed in one vocational high school is described here

HEALTH TEACHING is experiencing a real struggle for a place in the secondary school program. Definite plans for incorporating it in the program have been suggested in the recommendations of a national survey on secondary education,[1] and in the pamphlet entitled "Health Instruction in Grades IX-XII," by Dr. James F. Rogers.[2] In addition there are the recommendations of the White House Conference report.[3] The primary problem seems to be how to get health teaching into the secondary-school curriculum. Dr. Rogers says, in the summary of his pamphlet, "Hygiene is proclaimed from the educational housetops as of first importance to the student in his last four years of public schooling." Yet, "Under the [high-school] roof there is very little evidence that the matter is considered at all seriously."[2]

Progressive education has not affected the organization of the high school as markedly as it has the elementary school. The high-school curriculum seems more traditional and somewhat less flexible than the elementary-school curriculum. High-school faculties are a group of subject-matter specialists who, in spite of the fact they may accept the premise that the total personality of the child should be considered, are still thinking in terms of their own particular interests. One of the trends in education noted by the Committee on Secondary Education at the American Child Health Association conference in 1933 at Ann Arbor, Michigan, was a "definite trend toward giving more weight to children's interests and desires in solving health problems in the matter of curriculum construction." The committee felt that "this is a wholesome and sane trend, but that care must be taken to avoid a disregard of children's needs in favor of interests."[4]

The following account of what is being done in a vocational high school is built upon the principle that students' interests, needs, and desires should guide the selection of subject matter and healthful experiences. Almost the entire success of such a venture depends upon the attitude and continued interest of the school executive and the teaching staff. The principal of the particular school whose program is described here had the vision to realize some of the needs, as well as the possibilities, of health work in his school, and requested that a teacher be provided. It was my privilege to be allowed to try the experiment. This was three years ago. Now we have three classes for boys taught by the athletic coach who is also a social science teacher, and one of the two girls' classes is being taught by another member of the staff who has special qualifications for guiding girls in healthful living.

This particular high school has a registration of about 2100. Its purpose is to prepare students for definite vocations. As the title indicates, many of the courses are vocational in nature:

commercial, general industrial, and homemaking subjects which meet a real need. The training of the first two or three years is of a more general character and in the last year each pupil is expected to specialize in a definite vocation.

This elective health course, which meets daily for a term and gives 2½ credits, was started with a small group of twelve senior girls. We spent the first few weeks getting acquainted and finding out the courses that included anything about health, which the different members had had in high school. This background proved to be health education in the elementary school, general science, home economics, social studies, and sociology. They decided they had quite a little general information, but there were many questions pertaining to health that they would like to have answered. These proved to be the beginning of a cumulative list which led to research committees, class reports, excursions to observe and procure first-hand information, and both individual and group conferences—but very few of the old-type recitations.

One of the important findings each class makes, during the first few weeks, is that they apply very little of what they know in health. Consequently the class makes, as one of its aims, living healthfully, based on the principle that knowledge alone does not necessarily influence behavior.

The first group were pioneers and really blazed the trail. There were so many questions to answer concerning health that we decided to have units on some of the topics. The care of the skin was the first topic of consuming interest and presented the greatest number of questions. Fortunately, perhaps, we had no one textbook which we could consult, so we went to the few texts in health which had been placed in the school library—to science books, popular magazines, and some health publications. That first class really should have been beautiful if, according to our psychologists, "knowledge functions most effectively in guiding behavior when we go out and seek it to show us how to do something." We even had a demonstration of correct make-up. We studied face powders through the microscopes and are still doing this, when the class members wish. This make-up demonstration varies with the personnel of the group, but we always have a display of powders, rouges, and face-creams used by the members of the class. The discussion during this unit indicated the need for a health examination. This is still a most important part of our health course and occurs early in each term. I have chosen this topic as one to elaborate upon, to show the uses made of it in carrying out our objectives to live healthfully.

HEALTH EXAMINATION

Since up till last year there has been no regularly scheduled health examination after the seventh grade, the girls did not know the school physician with the exception of those who go out for athletics. We therefore decided to invite him to come up and talk with us. Each time he explains the purpose of the health examination and urges the girls to bring any questions they may wish to ask, when they come for the examination. For further preparation in class we take the health-record cards which are used, and go over them carefully in order to be sure the symbols are all understood. When the health examination takes place the doctor is very careful and patient, realizing that he is helping to develop very definite attitudes toward future health examination. Ernest Groves says in a discussion of health examinations in his recent book, *Understanding Yourself*, "The psychic part of the problem is not at present considered as much as it deserves."[5] He says we should take into consideration the emotional reactions, the possibility of the harm that may come to the over-

imaginative, or those who do not understand the meaning of the doctor's findings or who may exaggerate their importance. The idea is given the students that although they are not sick neither do we want them to be. Some may exaggerate their physical ills; in this case the doctor, the nurse, the dean of girls, or the health instructor talks to them. This is time consuming, but most worth while. We try to develop in the student a wholesome, objective attitude to face such facts squarely.

If students are really in need of medical care, the doctor urges them to consult their own family physician; sometimes he calls their physician and gives him a brief explanation of his findings. The students are made aware that this health examination is a sensible way of finding out one's health resources and limitations.

WEIGHT-CONTROL GROUP

Another use made of the health examination is the formation of a weight-control group. The scales are brought into the classroom once a week and each girl records her weight on her individual graph. About once a month these graphs are exhibited, and the class and the teacher offer commendations and suggestions. Since all of the girls in this high school are required to have a year in home economics, they have a good general understanding of food selection. Special problems call for conference work and many times additional advice from the doctor, with home visits by the school nurse, or myself.

Dental defects are among the first to be corrected. The students beam with pride when this defect is cleared on their health record card.

Eyestrain occurs in many cases; in one group 13 percent needed glasses. Often it takes the combined efforts of the nurse, the dean of girls, and the parents to procure the glasses, but the results are again most worth while. For some the relief from eyestrain means a gain in weight; in others, less irritability and nervous strain; and very often higher scholastic marks with greater satisfaction.

This year I am trying the experiment of "visiting" with one or two girls in my class each morning before school. Due to crowded conditions we have no homerooms, so the students go directly to the first recitation room when they come into the school. This is a most informal time; some students are studying, while others are reading references on health. In this way I get to know the girls and can study their needs, do some special conference work, and help them with their health problems. I have found the atmosphere much different—much less strained and formal—than when I used to spend the time getting my classbook ready and putting assignments on the board. This work is now delegated to students.

HANDICAPS CORRECTED

Several girls from each group have had diseased tonsils, and in one case the doctor found a bad heart condition, anemia, and extreme malnutrition. The girl, a senior, was immediately excluded from school, consulted her family physician, and made her own arrangements for a tonsillectomy. She was out of school three weeks, returned, made up her work, and gained six pounds during the remainder of the term. In this case the teachers of other subjects were very understanding and helpful. They made it a pleasure for this girl to return to her classes without a feeling of pressure from the work which she had to make up.

Comparatively few girls are found without foot defects. Some are extreme cases. In one group of 75, we had only three that the doctor found with perfect feet. The problem of meeting this situation is somewhat discouraging since this high school has no gymnasium or teacher of corrective work. A well trained physical- and health-education

person is invited during each term to give some special exercises. Once each week after that, we practice two or three exercises. Newspapers are placed on the floor in the aisles; the girls remove their shoes, and we try to actually see our improvements. Various incentives have been devised to motivate the continuing of these exercises at home. During the units on posture and feet, committees go to the local shoe stores and select shoes that are suitable for school and dress occasions. The shoe stores are exceedingly coöperative in loaning these exhibits. So many students remark that they are able to select their shoes with much more confidence after they have studied about feet and shoes.

ACTIVITIES

Some activity accompanies every unit we study. For instance, with colds, we have an exhibit of the remedies which the students use in their homes. Often, medical questions growing out of these are referred to the school physician. Some of the powers and limitations of the national Food and Drugs Act applying to the sale of patent medicines are explained. The students get an idea of what this act covers, and realize it does not apply to claims made in advertisements such as those carried in newspapers and billboards. Since knowledge must compete with general community practices and standards in control of conduct, students must be educated to believe that medical science and its findings are a more trustworthy guide for giving them the satisfaction that they crave than something their neighbors recommend.

Just now we are in the midst of a study of tuberculosis, and the tuberculin test will be given in the eleventh and twelfth years. Two years ago we had our first experience with this test and 70 percent of the students in those grades took the test. Since every student is required to take English, the English teachers presented this question. This is another example of the coöperation of the staff of teachers. The head of the English department and I met with the teachers, explained the procedure, and gave some scientific information about tuberculosis and the test. The librarian furnished the references both for the teachers and the students. Several students were selected to talk to each English class on the subject of tuberculosis. Members of the health and salesmanship classes were chosen in so far as possible. During this unit the school nurse makes the arrangements for a committee to visit a local clinic to see what is done for the tuberculosis patients of the community, and a large group always visits the sanatorium to observe the care of the patients there. Reports of these trips are made to class members who could not go. There was a decided change of attitude toward the test last year as compared with the previous year.

QUESTIONS ASKED BY STUDENTS

At the beginning of almost every unit, I ask for an assignment of questions which the students would like answered while we are studying the topic. This tends to make them think through facts learned in general science, home economics, and sociology; it catches their interest; and it guides us somewhat in our selection of facts and decision about where we will place the greatest emphasis. These are examples of some questions which have been asked concerning the unit on tuberculosis:

How much money is spent on tuberculosis research work every year?

Is tuberculosis contagious if you are not in a run-down condition?

Is tuberculosis curable?

Is it true that as a child grows up and his contacts increase he is likely to get tuberculosis germs in his body?

Has climate anything to do with getting tuberculosis?

How do farm people, who use unpasteurized milk, keep tuberculosis germs out of their bodies?

Should a person undergoing treatment for tuberculosis have children?

Why is tuberculosis called a family disease?
Would a patient having tuberculosis have any effect on the health of infants living in the same place?

Again, in considering the posture unit, these questions are taken at random from a collection made from the classes.

What effect has posture on health?
Are the classroom seats proper for good posture?
Will the carrying of books to and from school cause poor posture?
Is roller-skating bad for the feet?
Do foundation garments help posture?
Why do we have poor posture when we have had five years of physical education in the grade school?

This year, in connection with the posture unit, the students have particularly enjoyed the books *Your Carriage, Madam* by Janet Lane[6] and *New Bodies for Old* by Dorothy Nye.[7] Several of the girls used the material from *Your Carriage, Madam* as the basis for special English assignments.

Some of the units have only a few questions—regarding the eyes and the ears, for instance. Two stock questions that every group seems to want to know concerning eyes are: "Will plucking my eyebrows harm my vision?" and "Will mascara injure my eyes?" We are fortunate in having sight-meters as part of our equipment, and since the classes have been using them, vision has become as interesting a topic as any of the others. The students have made a partial survey of the lighting in the school building, and made valuable recommendations. Desks have been moved in the administration offices so that better light may be secured; a number of teachers have assigned the girls who are taking the class in health, the privilege of properly adjusting the window-shades. As one of the assignments during this unit, the students write a description of the place at home where they study, with relation to the lighting. This affords excellent material for discussion and the application of facts learned.

Other units considered during the term are fatigue, mental hygiene, health superstitions, nostrums and quackery, and sex hygiene. The last named unit is left until the end of the term when the class and teacher have developed a sympathetic bond of understanding that will permit free discussion of intimate problems. The students have already had some fundamental background in science and sociology; we gather these together and present new scientific facts concerning reproduction. This is accomplished through class discussion, individual conferences, lantern slides, and the use of the projectoscope. These sex problems are discussed in the same manner as those relative to tuberculosis or care of the skin. More attention is given to the psychological factors of attitudes, feelings, and appreciations, and to the sociological factors of personal relationships and standards. A small amount of emphasis is placed on the so-called social diseases, syphilis and gonorrhea; much more emphasis upon the positive values of friendship, love, and family life.

SOCIAL LIFE OF THE STUDENTS

This high school has a well developed plan for recreation, which affords many opportunities for girls and boys to be together. The teachers have an understanding attitude and welcome student confidences concerning social affairs. One finds that frequently this guidance must be delicately passive rather than forcefully active.

You may think that all our attempts to put into practice our health knowledge have met with success. But health classes have to face some discouragement and try again. Through the cafeteria in the school an effort has been made to change some of the food habits of the students. One class made a survey of the foods purchased. Following this survey we set up an ideal lunch, taking into consideration the money the students had to spend, which was about ten or twelve cents. A joint committee from

the girls' and boys' health classes met with the cafeteria manager in the principal's office to discuss ways in which we could educate the student body in the proper choice of food. The art classes helped with attractive menus; but evidently the time wasn't ripe for changing food habits. We felt we made little progress except for the opportunity to work on a common problem.

The school librarian has been most coöperative and helpful. A special section has been set aside for books, and another for folders and magazines relative to health. In the classroom we have a special health file to which the librarian and class members contribute articles of interest. When a student brings in a clipping, she underscores the important points and reports them briefly to the class. This tends to stimulate critical, thoughtful reading and adds to interest in the advances of science.

STUDENTS MAKE SUGGESTIONS

At the end of each semester the girls are invited to write their suggestions relative to the omissions, expansions, or additions they have in mind for this course. The principal, the dean of girls, the school nurse, and myself have come to look forward with anticipation to these frank and honest opinions. We are continually incorporating the student suggestions into the course.

These suggestions are requested the last of the term and written outside of class. Since sex education is the last unit, the girls often express themselves quite freely about it. The following are some direct quotations:

I think that there are a few further opportunities that could be given in school for putting into practice what is taught in health class. For instance, we are taught that we are supposed to have good posture in sitting as well as being comfortable; in order to do this we should have a seat that is about the right size for us. I know that it is impossible to adjust seats for everyone in the school, but if at the beginning of the term, the teachers in all classes could allow the pupils to pick out a seat that is comfortable and about the right size for them, it would be most helpful.

. . . .

The examination by the doctor is a step we can take to improve our health. Some of us never go to a doctor for physical examination and a few are afraid. If a person, for instance, has a slight defect in his vision and never suspects it, this examination may be the means by which he can remedy this defect before it has reached its peak.

. . . .

I think sex hygiene should be taught particularly to all seniors. When a girl has reached her fourth year in high school, she is between the ages of 17 and 18. To me the unit on sex hygiene was most useful. I knew very little about it. My mother is in Poland and I live with my aunt. I haven't seen my mother for ten years. At the time when I was coming to America I was too young to be told about sex hygiene. My aunt has attempted to tell me about it, but has lost courage each time. When I told her about this unit, she breathed a sigh of relief to know that I was getting a few facts in school.

. . . . .

There is one decided change that can be made, especially in the library, and that is the lighting. There are so many rooms that are just terrible to try and study in. I think that is one reason for so many absences. The boys and girls strain their eyes trying to work in the poor light, and this oftentimes seems to cause a stomach disorder.

. . . .

I think health should be a year's subject, and then if you want to extend the units it will be possible because there will be more time.

As has been mentioned earlier, we feel very keenly that provision should be made for an opportunity to live healthfully—physically, socially, and mentally. What possibilities have been found? Provision has been made for better hand-washing facilities, and better room-ventilation. A class committee is elected who watch both heat and ventilation. An isolation row has been set aside in the classroom where students who have colds may sit. Better knowledge of lighting has resulted in an improved arrangement of shades and proper use of artificial lights. Comfortable seating is accomplished early

in the term using the seats that are most comfortable and where the light is best.

As for mental health, commendation is always given when improvement is shown. The teacher is always a contributing member of the group, and during reports and discussions remains in the background as much as possible.

MEASUREMENT OF OUTCOMES

What have been some of the ways in which we have measured our outcomes? Following are some of the specific results that we are able to observe:

1. *Correction of defects* as a result of the health examinations. This means many conferences with the nurse, together with home coöperation. Our foot exercises and weight-control group help to complete the picture of improvement in physical health conditions.

2. Helping the girls to plan a *more healthful program.* This may be their schedule of other subjects they are taking or arrangement of study periods, or it may be personal budgeting of time.

3. Development of *more scientific thinking,* thus combating quackery and a multitude of other types of fallacies.

4. There are many improvements in *health behavior*—the wearing of more suitable shoes, refraining from nail biting, taking more rest, limiting social activities, and selecting cosmetics with care.

5. *Attitudes* are constantly changing, although of course these are hard to measure.

6. As to the *facts learned,* objective tests are given at the end of each unit; but these tests are never emphasized.

There is much to be done toward guiding students in their practical application of health teaching, but as the administrative and teaching staff become more aware of how we are trying to live what we learn, the way will be much easier. Health cannot be taught completely even in five periods a week. The facts learned must fit in with the situations of which they are a part, and must be seen in their true relationship to everyday living. This means not only that health should be a subject in the curriculum, but that there should be a favorable opportunity for health behavior throughout the school, the home, and the community.

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CONTEST JUDGES

The Silhouette Poster Contest—with numerous entries that have kept the N.O.P.H.N. staff saying "A" and "Oh"—has closed on May 1, the "deadline" having been extended as announced in the March issue.

Some time before May 15, the judges will meet and select the winning silhouettes, out of which it is hoped that one will make a suitable companion poster to the nurse-silhouette with which you are all familiar.

The judges are Philip P. Jacobs, Ph.D., Director of Publications and Extension, National Tuberculosis Association, Isabel L. Towner, Librarian, National Health Library, Nell V. Beeby, Assistant Editor, *American Journal of Nursing,* and Eleanor W. Mumford, Assistant Director, National Organization for Public Health Nursing.

A Play-Yard for the Baby

By KATHERINE BROWNELL OETTINGER
Mental Hygiene Supervisor, Visiting Nurse Association of Scranton and Lackawanna County, Scranton, Pennsylvania

A mental hygienist who is the mother of two children discusses the constructive aspects of the use of a play-yard for the infant and toddler

EMPHASIS is rapidly swinging from problem children to the problems of children. From infancy, play-life* is one of these problems. We cannot consider a baby's routine without ample and proper resources for his hours of activity. Constant attention from adults interferes with the joy and profit of play. What do we suggest when the growing ability of the child to move and explore endangers him if he is left without guidance?

The play-yard seems the best answer to the needs of the creeping baby, providing all the advantages of an especially equipped room. A wise use of the play-yard gives opportunity for freedom in play without too great restriction. Here the baby may be placed from the time he is able to sit up without danger of falling over. As he learns to crawl and pull himself up, there is a chance to grasp the sides of the pen and safely manipulate and coördinate his body until he is able to navigate.

He is strengthening his back. All the muscles of his body are preparing themselves for that minute when he can walk alone! Too many mothers feel that walking is merely a matter of readiness of the legs. But let them remember any experience in trying to walk after they have been confined to bed. They will realize it is not enough to stimulate their child to walk while the rest of his body is hampered in its opportunity to move, stretch, and pull. The "walker" illustrates this misconception of the principles of bodily development. In the play-yard by holding the sides he can walk across unaided as soon as he is ready; but he will not be forced one minute before he is prepared for that step.

FOUNDATION FOR INDEPENDENCE

Free, too, is he from the perpetual "do's" and "don'ts" of many adults. He may use his play material in his own way without direction. Only the things which are safe and helpful are placed within his reach. Toys that develop sensory experience may be placed within the yard or tied to its sides, so that it is just as much thrill to pull back the toy as it was fun to toss it over the sides. Nobody need come to his aid in reclaiming the lost article. He can set the foundation for independence, initiative and concentration.

He can investigate the material of his small world without haste or over stimulation. Everyday occurrences, un-

*Play-life, as distinguished from the usual conception of play as mere amusement or entertainment, signifies the activity that springs from within the child without external regulation. To gain widespread profits in developing the mind, body, and emotions, this play must be without social constraint. Conformity, not to people, but to the laws of nature, discovered in falling, lifting, feeling, etc., allows the child to reap the benefits of this richer meaning in play-life. Freedom to express the initial urge to activity is the keynote of true play-life.

noticed by the adult, are unbelievably new and exciting to a child. If a sunbeam passes across the yard, he has time to watch it, to try to catch it, to think about it, without some anxious adult distracting him by jouncing a bunny up and down, or compelling him to listen to babybells jingle. He can make his own noises. He will discover

Free to explore in a homemade play-yard

the things around him at his own rate of speed. The habit of success becomes the backbone of his experience for he has never been discouraged by having to undertake too complicated achievements. Nor has he been deprived of the sense of accomplishment by excessive babying when his unfolding capacity permits conquering larger fields.

Mothers who are horrified by the idea of any restriction of liberty declare that they will never keep their child a prisoner in a "play-pen." This attitude, translated to the baby, creates rebellion on his part. For this reason the term "play-yard" rather than "pen" may indicate to the mother the genuine feeling of security which the baby receives in this small area which is distinctly his own. Properly trained from an early age to accept play in the play-yard for a prescribed amount of time daily, the baby feels towards the play-yard a friendliness and security akin to that which an adult feels for his home. A crib is too soft to be a satisfactory play-yard and it should be associated only with the idea of sleep. A high-chair gives no opportunity for movement of the larger muscles. But the play-yard creates a safe place where the child may learn by doing. He gains courage to attack ever larger physical problems as he learns to walk, climb, and run. A foundation which encourages dealing with physical things is promoted through the security of early experiences in the yard.

SOCIAL ADJUSTMENT

Fortunate is the baby who is dressed in a sun-suit, given toys carefully selected for his age, and placed in the play-yard without adult supervision. He is building a healthy attitude toward social relationships. If the baby has to be under constant surveillance in order for the mother to assure herself that he is safe, he rapidly learns to dominate the household by fretful crying and pleas for entertainment; while a baby left alone relies upon his own resources rather than idle attention-getting devices.

His mother may place the play-yard in a well ventilated room where he can be quite by himself. If near a window, he can watch the world outside. In the warmer months she may feel safe in putting it on the porch or in the yard. Secure in his play-yard, while she is busy with household chores, the baby will thus benefit from the direct sun, which the mother is often unable to give him otherwise during the best hours of the day.

Too great dependence on adult companionship interferes later with his adjustment to companionship with children of his own age. The need for com-

panions in his play-life does not appear until the child is about two years old. Two infants playing in the same room pay very little attention to one another. The child's early need is to feel, hold, taste, and learn to manipulate things himself. Simple toys such as a spoon in a cup, boxes, and empty spools of thread on sturdy tape answer this need for the young child. Thus with a minimum of distraction he concentrates on his own interests of finding out about this strange world! The comparative isolation of the play-yard meets the needs of this stage of mental growth and is closely associated with skil! in managing physical movement of the larger and smaller muscles. The baby who is carried around the house, constantly talked to, or taught tricks, is robbed of these essential privileges of childhood.

PHYSICAL SAFETY

Apart from these mental health aspects, the physical safety which the play-yard offers is reason alone for its consideration. The baby naturally picks up and examines all foreign articles which come within his sight. A dirty crumb on the floor gives him impetus enough to scamper across the kitchen, seize upon it, and put it in his mouth. These tempting objects are frequently dangerous. Any mother will tell you that the coal-pail is a first port-of-call. Her nerves become frayed and her temper short protecting her child from things which endanger his safety: the stove, the washing machine, the precipitous steps.

It is not necessary to reiterate the hazards in first years of childhood which take their tremendous toll in unnecessary accidents. Further physical ills may also be reduced by removing the baby who is just learning to walk from the cold floors and drafts. The play-yard is a far cry from the Italian fascia for wrapping babies, but the principle of physical safety is the same that directed these mothers who worked in the fields to keep their infants safe from harm.

MISUSE OF PLAY-YARD

The play-yard, for varying periods of the day, is useful from the time the baby is able to sit up until he is able to climb out of the yard. But it would be a gross misuse if the child were automatically dumped there whenever the family wanted to shirk caring for him. Always the baby must have a definite period of play outside the yard with the happy companionship of other members of the family. This play-time increases in length with the age of the child. It provides a chance to creep, or later to walk, push, pull, lift and fully exercise his growing knowledge and skill. If he has learned to accept the play-yard from an early age, there will be no difficulty in his becoming accustomed to it. Any extension of his liberty thereafter offers fascinating possibilities. The play-yard has saved him from the boredom of having already conquered all his worlds.

HOMEMADE PLAY-YARD

If finances preclude the purchase of a play-yard, the ingenious father can fashion a sturdy and well proportioned one from old boxes. If boxes are used for construction of the floor, it is well to cover them with heavy canvas to avoid the risk of splinters. The sides can be made of window screening, but the ends of wire must also be carefully covered. Such a contribution to his child's welfare offers one splendid opportunity to help rebuild his sense of selfhood in the face of curtailed earning capacity. This may even open up to him endless possibilities of other homemade toys and eventually a back-yard playground.

The play-yard provides the first requisite for good play habits. A place to play! Full, rounded living demands that play serve a wider purpose than just keeping the child quiet. No one who has observed how much a child learns

through play can feel that a toy is only a giver of pleasure. It influences the development of the child's personality; it contributes to richness of living. Joseph Lee in his discussion of Play and Education maintains that play is a powerful enchanter, calling forth the child's whole self.[1] It is the parent's job to provide proper environment and then leave the child alone to develop.

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[1]Lee, Joseph. Play in Education. The Macmillan Company, New York, 1915.

Tilson, Agnes. Homemade Toys and Play Equipment. *The Farmer's Wife*, St. Paul, Minnesota, 1933.

Roberts, Mary Price, Ph.D. When Children Play at Home. Pamphlet 52, Extension Bulletin 300, University of Iowa, Iowa City, Iowa, 1932.

Leonard, Mrs. Eva A. Best Toys for Children and Their Selection. Wisconsin Kindergarten Primary Association, Madison, Wisconsin, 1925.

GUIDE POST FOR BOARD MEMBERS

The beginning and early years of the N.O.P.H.N. as remembered by one of the founders are described with vivid word-pictures of early scenes, on page 275.

A distinguished gentleman and physician tells why he considers the work of the public health nurse to be indispensable in a public health program. Page 273.

The way in which a local public health nursing agency functioned in giving service to the community during the recent flood disaster of the Mississippi Valley is told on page 312.

Should a play-pen be used for the toddler? A mental hygienist believes that a play-yard—when used constructively to give the baby a chance for free activity rather than as a place of incarceration—holds many physical and social values for the child. Page 299.

The need for more nursing care of communicable-disease patients in their homes is forcefully brought out in an article by the Director of the Nursing Service of the Metropolitan Life Insurance Company. Page 283.

A health program in a vocational high school is described on page 292.

Some of the findings in a recent study of nursing service in the homes in the Metropolitan area of New York are summarized by the Associate Director of the N.O.P.H.N. on page 289.

The activities of a workshop for the treatment and rehabilitation of the crippled are outlined in an article on page 280.

The Public Health Nurse in the Control of Syphilis and Gonorrhea

By GLADYS L. CRAIN, R.N.
Epidemiologist, Massachusetts Department of Public Health, Boston, Massachusetts

Part V

What Do You Know About Syphilis?

Can you answer these questions? A review of the material on syphilis in preceding articles of Miss Crain's series is given here in the form of questions. We hope they will be useful for staff educational programs and also for individual readers who wish to be thoroughly informed in regard to all phases of this important disease

THE DISEASE SYPHILIS

1. Where did the name "syphilis" originate?

2. What two theories exist regarding the antiquity of this disease?

3. What are the signs of primary syphilis?

4. How soon do the organisms of syphilis get into the blood stream?

5. What is the primary lesion of syphilis called? When does it usually appear? Where is it usually located? Where else may it be found? Why is this lesion frequently missed in medical examinations?

6. What are the signs of secondary syphilis?

7. Name the common infectious lesions of primary and secondary syphilis. Under what circumstances are these lesions dangerous to others in non-sexual contacts? Upon what tissues are the open infectious lesions of syphilis usually located?

8. What is the usual range of time between exposure to syphilis and the appearance of secondary symptoms? For how many years may untreated syphilis be infectious?

9. What is recurrent secondary syphilis?

10. What important organs of the body may be affected in tertiary syphilis?

11. Is tertiary syphilis infectious in non-sexual contacts? In sexual relations? Can a pregnant woman with tertiary syphilis infect her unborn child?

12. How many forms of neurosyphilis are there?

13. What is so-called latent syphilis?

14. What is congenital syphilis? How is the disease transmitted? How can it be prevented?

15. What are the characteristic symptoms of syphilis in a newborn baby? The common signs of late congenital syphilis?

16. What are rhagades? What is interstitial keratitis? With what other disease may it be confused? What is the Hutchinsonian Triad?

17. When is congenital syphilis communicable? When does it cease to be communicable?

18. What is the significance of the statement, "Syphilis is a family disease"?

THE CAUSATIVE ORGANISM OF SYPHILIS

1. What is the causative organism? What are its chief characteristics?

2. By whom was the organism discovered? When?

3. Compare the possibility of exposure to syphilis and exposure to tuberculosis in terms of viability of the organism and the method of transmission.

4. Is the organism of syphilis resistant outside the human body? Under

what conditions does it thrive? How can it be killed?

5. What structures in the body may it attack? What is its usual portal of entry into the body?

6. Does the organism attack any other than the human animal?

7. What is the incubation period of syphilis?

8. What contribution did Metchnikoff make to the study of syphilis?

9. Can the organism of syphilis be successfully grown on culture media? Can it be stained satisfactorily? How can it be seen? What is a darkfield condenser?

10. What are Koch's postulates?

DIAGNOSTIC TESTS FOR SYPHILIS

1. What is a blood test? Is it a direct method of diagnosis?

2. Name two types of blood tests. Name several modifications of these types.

3. Why is a negative blood test unreliable in primary syphilis? In treated syphilis? In late syphilis? In neurosyphilis? In pregnancy?

4. Why is a spinal-fluid test performed on patients with syphilis? Is it an important procedure if the patient's blood is negative? Give reasons.

5. Is a positive blood test in a newborn baby always evidence of infection with syphilis?

6. Does the blood test determine the infectiousness or non-infectiousness of the disease?

7. What is a colloidal gold test? Is it a specific test for syphilis?

8. What is a Micro-Hinton test? Has this test any advantage over the Wassermann?

9. By what method is the diagnosis of syphilis in the seronegative primary stage of the disease accurately arrived at?

10. What does the term sensitivity mean when applied to any type of blood test? What is the meaning of specificity?

TREATMENT OF SYPHILIS

1. Will the signs and symptoms of primary and secondary syphilis disappear without treatment?

2. Why is it important to diagnose primary syphilis before blood tests are positive?

3. What is the relative curability of primary syphilis with negative blood? Of primary syphilis with positive blood? Of secondary syphilis?

4. What is the main objective of treatment in tertiary syphilis? (To make the blood negative? Cure the patient? Arrest the progress of the disease?)

5. What is arsphenamine? Who first produced it? When? What modifications of this drug are in common use for the treatment of syphilis?

6. When was bismuth first used in the treatment of syphilis? Who first pointed out its therapeutic possibilities?

7. What are the signs of intolerance to the arsenicals? What is a Herxheimer reaction? A nitritoid crisis? What is a common symptom of intolerance to bismuth?

8. What is the minimum period of treatment for early syphilis?

9. How many injections of arsphenamine and bismuth have been set as the minimum for the control of syphilis in pregnancy?

10. What is the purpose of treatment in pregnancy? Does it cure the patient?

11. Upon what principles does the medical control of syphilis depend?

SYPHILIS AND THE PUBLIC HEALTH

Which of the following procedures are immediately important in caring for each of the patients described from 1-8 below:

a. Removal from work?

b. Hospitalization?

c. Intensive medical treatment: to control infectiousness; to prevent congenital syphilis; to arrest the destructive progress of the disease?

d. Epidemiological follow-up of

sources and contacts? Examination of family contacts?

1. A milk handler (married) with a primary genital lesion of less than one week's duration.
2. A laundress (single), 60 years of age, with tertiary syphilis.
3. A school child with congenital syphilis.
4. A bus driver (married) with early secondary syphilis (healed lesions) under continuous treatment.
5. A housekeeper (widow), 55 years of age, with latent syphilis. Has had disease 10 years. Takes care of young children.
6. A man employed as a baker (married), 28 years of age, with congenital syphilis.
7. A pregnant woman 25 years of age, with tertiary syphilis. Has two small children. Is a saleswoman in a department store.
8. A hairdresser (single), 21 years of age, with "open" secondary syphilis.

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(To be continued)

BOOKKEEPING GUIDE

The Service Evaluation Committee of the National Organization for Public Health Nursing has prepared a Bookkeeping Guide* which supersedes the bookkeeping system formerly recommended by the Committee. This guide consists of a set of instructions with an illustration of how entries are made on the suggested bookkeeping sheet. The introductory material states:

"In preparing this material, the present requirements of the cost-of-visit statements prepared for the insurance companies have been considered. Also, before publication, these instructions were checked with Community Chests and Councils, Inc., so that there is no conflict with regulations on budgets issued by that organization. However, before making any decision on a bookkeeping system, chest agencies should consult with the auditor of the local chest to insure having the budget information which he may require, available from the forms as they are set up."

This material can be used by the agency as a guide to setting up its own system. Inexpensive standard columnar sheets on which the column headings can be filled in are suggested. The sheets are available from commercial stationers, in bound books. Variations in program make uniformity difficult. Some standard is, however, essential, and with the sheets recommended modifications can be made readily.

The guide includes instructions relative to a record of:

1. Receipts including both cash received and the cash value of all donations received.
2. All disbursements.

The expenses shall be the cash expenses incurred by the association and the cash value of the donations used in the interest of or by the association. It is designed primarily to meet the need and problems incurred in public health nursing agencies.

3. Certain ledger accounts.

*Single copies of this guide are free to members of the N.O.P.H.N. Copies can be secured by non-members, and additional copies by members, for 10 cents each. National Organization for Public Health Nursing, 50 West 50 Street, New York, N. Y.

In Memoriam

The smoke ascends
In a rosy-and-golden haze. The spires
Shine and are changed. In the valley
Shadows rise. The lark sings on.
The sun, closing his benediction,
Sinks, and the darkening air
Thrills with a sense of the triumphing night—
Night with her train of stars
And her great gift of sleep.
So be my passing
My task accomplish'd and the long day done,
My wages taken, and in my heart
Some late lark singing,
Let me be gather'd to the quiet west,
The sundown splendid and serene,
Death.

The Lyre of Alpha Chi Omega, June 1936

Again in May we are listing those public health nurses who have died during the last year and as before we are requesting our readers to send us word when any of our number pass from among us.

Nelle E. Baker. Public health nurse, Johnstown Chapter, American Red Cross, Johnstown, New York.

Catherine Cassidy, February 25, 1936. Formerly public health nurse, Youngstown Visiting Nurse Association, Youngstown, Ohio.

Anna M. Cavanaugh, December 14, Waterbury, Connecticut. Formerly public health nurse, The Waterbury Visiting Nurse Association, Waterbury, Connecticut.

Caroline Watkins Chichester, April 11, 1936. Former member of the staff of the New York State Department of Health.

Isobel Clarke, May 10. Director of the School of Nursing, Buffalo City Hospital, Buffalo, New York.

Mary E. Clarke. Public health nurse, Toledo District Nursing Association, Toledo, Ohio.

Mrs. Clara Coburn, October 24. Public health nurse, Portage County, Ohio. Killed in automobile accident.

Mrs. Grace M. Cocks. Public health nurse, Visiting Nurse Association, Newark, New Jersey.

Ada Boone Coffey, May 8. Former extension secretary in public health nursing of New York State Department of Public Health and chief supervising nurse of Massachusetts State Department of Public Health. Died in Portland, Oregon, at the hospital established by her brother, Dr. Robert Coffey.

Genevieve Coon, June 25. Public health nurse, Monroe Chapter, American Red Cross, Monroe, Michigan.

Dorothy M. Dalrymple, July 31, Seattle, Washington. Formerly public health nurse, Humboldt County, California.

Mrs. Ada Harris Day, February 5. Bay Village, Ohio. Mrs. Day had been a member of the National Organization for Public Health Nursing since 1918.

Mrs. Kathleen Johnston DePasquale, December 17, North Providence, Rhode Island. Formerly public health nurse, Public Health Nursing Association, Woonsocket, Rhode Island.

Lucia Freeman, June 18, Washington, D. C. Formerly public health nurse, American Red Cross, Fayetteville, North Carolina.

Mamie Glendenning. Public health nurse, Public Health Nursing Association, Louisville, Kentucky.

Lillian Hagelweide, October 19. Died at nurses' residence of Ulster County Tuberculosis Hospital, New York. Formerly public health nurse, Saugerties, New York.

Mrs. Anna Hiester, May 13. Formerly public health nurse, Visiting Nurse Association, Reading, Pennsylvania.

Elizabeth W. Holt, May 30. Director, Visiting Nurse Association, Dayton, Ohio.

Laura M. Johnson, October 9. Flushing, Long Island, New York.

Janet McKay, July 27. Assistant Educational Director, Visiting Nurse Service, Henry Street Settlement, New York, New York. Killed in an automobile accident.

Fannie Marcus, October 9. Special tuberculosis clinic nurse, Division of Health, The Office of Indian Affairs. Formerly with the Pima Indian Agency, Sacaton, Arizona.

Pauline Myrdal, January 22, 1936. Public health nurse, Fort Wayne, Indiana.

Clara D. Noyes, June 3. National Director, Nursing Service, American Red Cross, Washington, D. C.

Caroline L. Peet, March 29. Public health nurse, Visiting Nurse Association, Syracuse, New York. Killed in an automobile accident.

Charlotte Phelps, December 19. District nurse, Circleville, Ohio.

Mrs. Neva Beattie Studd, January 5, Grand Rapids, Michigan. Supervising nurse, Kent County Health Unit, Michigan.

Mary L. Wyche, August 22, at Wychwood, near Henderson, North Carolina. Formerly public health nurse in North Carolina.

Two Unpublished Letters

Miss Florence Nightingale.

Dear Miss Nightingale:

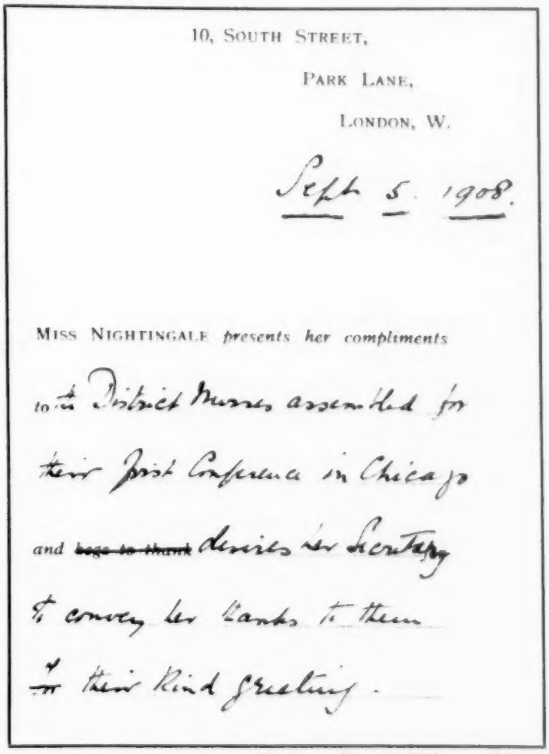
District nurses in America are today holding their first Conference. Informal as it is, we feel that you will care to have our greeting at this time. We hope the same spirit which pervaded your beloved work at Kaiserswert, has been handed down to us through all the years, and that the inspiration which came to you there, is resulting year after year in giving better care to the sick in the homes of the poor. With our warmest greeting, we are,

Very faithfully yours,

(Signed by 108 visiting nurses)

Two heretofore unpublished letters which were exchanged in 1908 between a group of 108 visiting nurses in America and Florence Nightingale, are reproduced here in commemoration of Miss Nightingale's birthday. These letters mark a milestone in the development of the National Organization for Public Health Nursing, whose Silver Jubilee is being celebrated this year. The letter to Miss Nightingale was sent at the close of a meeting in Chicago, Illinois, in April 1908, which was "called by the Chicago Visiting Nurse Association to discuss the value of a national seal as a means of bringing visiting nurses closer together in the interest of better standards of work," and to "discuss some of the administrative and service problems which they were facing."*

*From an unpublished manuscript on the history of the N.O.P.H.N. by Ann Doyle, R.N., by whose permission these letters are reproduced in advance of the publication of the history.



10, South Street,

Park Lane,

London, W.

Sept 5. 1908.

Miss Nightingale *presents her compliments*

to the District Nurses assembled for

their first Conference in Chicago

and ~~hope to thank~~ desires her Secretary

to convey her thanks to them

for their kind greeting.

Courtesy Harriet Fulmer, Chicago

Prevention of Accidents in the Restaurant Business

By JOANNA M. JOHNSON, R.N.
Chief of Industrial Nursing Department, Employers Mutuals, Wausau, Wisconsin

Every industry has its own hazards which must be studied carefully if accidents and illness are to be prevented. A nurse with a wide knowledge of industrial hazards discusses accident prevention in one industry

NO ONE can benefit more from a program for the prevention of accidents than can the restaurant and hotel operator. This is a highly competitive field, in which the keynote of success consists of courteous service and efficiency. Few industries have such a large proportion of employees in constant contact with the public, and accidents can disrupt that service without warning. One sprained wrist, one infected blister may upset the morale of the worker and may necessitate the replacing of an experienced employee, at the cost of service to the customer and at the cost of the good will of the employee; for strange as it may seem, an injured worker seldom thinks kindly of an employer in whose plant he has been injured, regardless of the treatment or the care and thought which has been given him.

Under the bugbear of "overhead" are listed waste, unsaleable goods, spoilage, depreciation, and accident costs. Accident costs can no doubt be determined as a definite amount at the end of the year, but in addition there is the waste which these accidents cause in suffering, loss of time, and loss of a full pay check—which in turn brings an economic loss to the family and to the community.

Hidden costs of accidents not covered by the insurance policy are estimated as four times the amount of the known expense. These costs include such items as interrupted service to the customer and to the employer, turnover of labor, and loss of time of the employee from work, necessitating the use of a relief worker, who may be an untrained person. This distraction is felt more keenly in the dining room, since serving the public requires an active mind concentrated on the matter at hand. Any distractions which disturb that smooth functioning, reduce the efficiency of service.

Efficient production results from careful supervision; this is as true in the restaurant business as it is in a manufacturing plant. The time and thought which the manager gives to the prevention of accidents will repay him many times in real dividends. It will result both in money saved and in the elimination of suffering The successful safety records obtained in industry have resulted from the application of a few principles, the chief of which is "interest." The restaurant manager can stimulate that interest among his workers so that they too will become safety conscious and will bring to their homes and to the public the benefits thereof.

No accident can be considered trivial. A small scratch, the tiniest prick may produce a serious infection. A blister

Presented at the 1937 Midwest Hotel Show, The Illinois and Greater Chicago Hotel Associations, Chicago, Illinois, March 24, 1937.

improperly cared for can result in an infection which may cause a loss of life. Germs are no respecter of persons. First aid is essential to the care of all these injuries and it is important that it be given the consideration which it deserves. Having a properly equipped first-aid kit is not costly; having a responsible person who has had some training in first aid is a requisite for maintaining a good safety record. First aid, however, should never take the place of adequate medical care.

HAZARDS IN RESTAURANTS

The prevention of accidents requires a study of the causes. What are some common causes of injuries in restaurants? Burns rank high and are the source of much suffering and lost time. Their cause is legion—uncovered heating pipes, the careless handling of hot utensils, long-handled basins, improper handling or placing of kettles which are filled with hot liquids. Accidental contact with oven surfaces and other hot parts of the kitchen range is common, particularly when the work is rushed.

Accidents resulting in cuts and lacerations are numerous and are caused frequently by broken dishes, unguarded bread-slicing machines, careless opening of cans, and improper handling of knives. Collisions occur at blind corners, through swinging doors, and in crowded aisles. Falls of persons often interrupt the routine work and are caused by slippery floors and excessive haste, by dark stairways and unprotected trap-doors. Electrical hazards are ever present where wiring is not properly maintained. Ladders which are fit only to be discarded are frequently used and cause many serious injuries such as dislocated shoulders, fractured wrists, and even fractured skulls. Unguarded machinery has no place in the well established restaurant. Foreign objects in food are a public nuisance and are often caused by food containers being left uncovered and by broken china being carelessly discarded. These are a hazard to the customer as well as to the employee.

All of these items and many more come under that important subject of "good housekeeping." Surely in an industry where the serving of food is a personal service, one should give serious thought to this factor which will at the same time create a safe place of employment for the worker and increase his efficiency.

Unlike staple commodities, accidents have no fixed cost. They may vary from a minimum of a few dollars to thousands of dollars. A good accident record requires constant vigilance on the part of the management and the understanding coöperation of the trained employee. The organization and carrying out of an accident prevention program is not difficult, nor does it involve any large expenditure. It does require active and interested participation by the highest executive, for the attitude of the supervisors and the employees is but a reflection of that of their superior.

Knowing as we do that accidents are costly, unnecessary, and preventable, our attention and our efforts should be directed toward their elimination. These efforts will bring unlimited rewards. Among these rewards may be listed the good will of the employee and customer, since this is a fundamental principle of good business. Another reward is the peace of mind which comes from the knowledge that the worker has returned to his home in good health and free from disabling injuries and that the customer has been provided with a safe and delightful place of relaxation, as a result of the thoughtfulness and interest of management in the elimination of accidents and injuries.

NOTE: "Saving Eyes in Industry," by Vivian V. Jones, will appear in the June issue.

STUDENTS REGISTERED IN APPROVED COURSES

During the school year 1935-1936, there were 18 courses in public health nursing which met certain requirements according to the standards of the National Organization for Public Health Nursing. At present there are 17, since the course at Washington University, St. Louis, Missouri, was discontinued in June 1936. The table which follows gives details about student registration during the past school year in 16 of the 18 courses approved for that year. (Figures are not available for the courses at Fordham University, New York, New York, and the University of Hawaii, Honolulu, Hawaii.)

NUMBER OF STUDENTS REGISTERED IN APPROVED COURSES IN PUBLIC HEALTH NURSING AND NUMBER OF CERTIFICATES AND DEGREES GIVEN IN ACADEMIC YEAR 1935-1936 AND SUMMER SESSION 1936

State	Institution	Year	Total registration	Graduate students registered	Undergraduate students registered	On full-time schedule	On part-time schedule	Certificates given or full public health nursing program completed	Degrees given: B.S. or B.A.	Degrees given: M.S. or M.A.
Calif.	Univ. of California Div. of Nursing Ed. Berkeley	Year 1935-1936	100	80	20	100	....	31	20	....
		Summer Session	78	78	....	78	....	....	....	....
D. C.	Cath. Univ. of America[1] School of Nursing P. H. N. Division Washington	Year 1935-1936	27	27	....	5	22	5	....	....
		Summer Session	20	20	....	20	....	....	....	....
Mass.	Simmons College School of Nursing Boston	Year 1935-1936	87	57	30	87	....	17	10	....
		Summer Session	42	42	....	....	42	....	....	....
Mich.	Univ. of Michigan Dept. of P. H. N. Ann Arbor	Year 1935-1936	91	91	....	63	28	10	10	2
		Summer Session	133	133	....	133	....	....	....	....
	Wayne University College of Lib. Arts Dept. of Nursing Detroit	Year 1935-1936	588	578	10	29	559	60	4	....
		Summer Session	28	28	....	4	24	....	....	....
Minn.	Univ. of Minnesota Dept. of Preventive Medicine and P. H. Minneapolis	Year 1935-1936	448	427	21	361	87	37	17	....
		Summer Session	154	154	....	133	21	....	....	....
Mo.	Washington Univ.[2] School of Nursing Dept. of P. H. N. St. Louis	Year 1935-1936 Summer Session[2]	57	50	7	17	40	9	4	....
N. Y.	Columbia University Teachers College Dept. of Nursing Ed. New York	Year 1935-1936	307	307	....	3	3	4	15[5]	95
		Summer Session	161	161	....	No distinction		....	....	....
	Univ. of Syracuse College of Medicine Dept. of P. H. N. Syracuse	Year 1935-1936	64	64	....	22	42	10	....	....
		Summer Session	172	172	....	143	29	....	....	....
Ohio	Western Reserve Univ. Sch. of App. Soc. Sc. Cleveland	Year 1935-1936	66	61	5	55	11	36	....	2
		Summer Session	35	35	....	33	2	....	....	....
Oreg.	Univ. of Ore. Med. Sch. Dept. of Nursing Ed. Portland	Year 1935-1936	25	25	....	20	5	19	8	....
		Summer Session	26	26	....	26	....	....	....	....
Pa.	Univ. of Pennsylvania[1] School of Education Dept. of Nursing Ed. Philadelphia	Year 1935-1936	65	65	....	4	61	....	....	....
Tenn.	George Peabody College for Teachers Dept. of Nursing Ed. Nashville	Year 1935-1936	204	204	....	196	8	25	6	3
		Summer Session	177	177	....	173	4	....	....	....

State	Institution	Year	Total registration	Graduate students registered	Undergraduate students registered	On full-time schedule	On part-time schedule	Certificates given or full public health nursing program completed	Degrees given: B.S. or B.A.	Degrees given: M.S. or M.A.
	Vanderbilt Univ., School of Nursing Nashville	Year 1935-1936	21	21	....	17	4	10	8	....
Va.	College of Wm. and Mary School of Social Work and Public Health Richmond	Year 1935-1936	20	16	4	20	....	15	4	....
Wash.	Univ. of Washington School of Nursing Ed. Seattle	Year 1935-1936	82	65	17	81	1	24	14	1
		Summer Session	75	74	1	75	....	....	....	....
		Total 1935-1936	2252	2138	114					
		Summer Session	1101	1100	1					
		TOTAL	3353	3238	115			308	120	17

[1]Course started in September 1935.
[2]Course discontinued in June 1936.
[3]Winter session: full-time 73, part-time 176. Spring session: full-time 85, part-time 194.
[4]Information not available.
[5]Approximate number.

Corresponding figures for the school year 1934-1935 are given in the January 1936 issue of PUBLIC HEALTH NURSING for 15 approved courses. The total course registration reported at that time was 2524; in 1935-1936 it was 3353, an increase of 829 students. Comparing the totals for the 14 courses for which data are available for both years, we find that the total registration during the past year was 3241, and for the preceding year it was 2447, an increase of 794 students. The summer registration for the same courses increased from 935 to 1081. The ratio of undergraduate students to the total registration in the courses is 4 percent, which is the same as it was during 1934-1935.

The number who received certificates or who completed the full public health nursing program in the school year beginning September 1935 was 308, as compared with a total of 244 reported for the preceding year. The most outstanding developments in the courses during the past year have been the increase in rural practice fields and the enlargement of urban fields to meet the needs brought about by the increased number of Social Security scholarship students. In still more courses this year the program has been increased from nine to twelve months, to allow a longer practice period for the student who has not had previous public health nursing experience.

ADDITIONAL SUMMER COURSES*

University of Alabama, University, Alabama

First term June 7-July 16, second term July 17-August 20. Courses in Principles and Methods of Teaching, Nursing Education, Tuberculosis Nursing, and Social Hygiene. Helen Stockton, Instructor in Public Health Nursing.

For further information write to John R. McLure, Director of Summer School.

University of Florida, Gainesville, Florida

July 19-24. Classes for public health nurses will be taught during a five-day institute.

For further information write to the registrar, University of Florida.

Boston University, Boston, Massachusetts

July 6-August 14. Courses in Mental Hygiene of the School Child, and in Health Teaching in Elementary and Secondary Schools.

For further information write to Professor Edward J. Eaton, Director, 84 Exeter Street, Boston.

*A list of summer sessions of interest to public health nurses appeared in the April number.

Caught in the Flood!

By LYDIA C. SCHLUNDT, R.N.
Acting Director, Evansville Public Health Nursing Association, Evansville, Indiana

A graphic story of how a nursing association coöperated with the Red Cross and carried on an emergency service to the community during the 1937 flood of the Mississippi Valley

AS THE FLOOD waters began to rise rapidly on Monday, January 25, all staff nurses of the Evansville Public Health Nursing Association were instructed to fill their nursing bags to capacity, to take an additional large brown paper bag with nursing supplies—enough to last a week if necessary—and if flood conditions should become serious, to keep in touch daily with our central office or with their supervisors, if in any way possible. There were some queer little smiles when I gave these instructions. In fact, I also smiled, while I admitted that it was doubtful whether such drastic measures would be necessary. However, we felt that public health nurses, of all people, should be prepared for any emergency.

Early the next day, the furnace in the Health Center could no longer be fired because of the lack of city water, and we evacuated the Center. The thought foremost in my mind at this time was that the Public Health Nursing Association must not fail the public, but must give continuous service in an emergency. As it was necessary to evacuate my own home also, I accepted the invitation of one of our supervisors to stay with her; and we left my home by boat—taking the dog with us. The next morning we had the Association telephones routed to her home.

It was not long before the water isolated us in this apartment. However, we discovered that we were situated on one of the two "islands" left high and dry in the southeastern section of the city of Evansville.

One of the physicians who resides in that same block asked us to give typhoid fever inoculations on our "island." So while I directed the work of the Public Health Nursing Association from these temporary headquarters, two of our public health nurses began the typhoid inoculations. These were also given in a grocery store on the other "island," the nurses going by boat daily. A total of 1287 inoculations were given.

One night we had an "S.O.S." call from two of our public health nurses, who reported that their basement wall had caved in, and that they had to leave their apartment at once. They were invited to join us, and after a thrilling trip by Red Cross truck and boats they arrived at 1:00 a.m. The next morning, one of them answered the Red Cross call to Morganfield, Kentucky, and a little later, the other answered a Red Cross call to Lewisport, Kentucky. In the interim they also helped with the immunizations.

POWDERED MILK FOR BABIES

Meanwhile, another problem arose. How would our many clinic babies obtain their necessary powdered milk? (Powdered milk is made available to needy babies and children through our child health conferences, upon the prescription of the clinic pediatricians, by the generosity of a private contributor. Eligibility for the milk is deter-

mined by the clinic supervisor, and the records of distribution are kept by the voluntary service of board members.) Upon inquiry, it was learned that the authorities at the Coliseum thought it best not to dispense the powdered milk from a central office, because it would provoke additional traffic. Accordingly, we had the newspapers and radio announce that parents of clinic children who had been receiving powdered milk should call our telephone number, and every effort would be made to get the milk to them.

The owner of a local department store which sells infant supplies exclusively, offered to let us dispense this powdered milk from his establishment, which was still high and dry, and which because of its central location was easily accessible. He also offered us a telephone service. Arrangements were then made with the Red Cross Transportation Department for two trucks to take the powdered milk from the Health Center garage to the store. As the requests for powdered milk came in to our temporary headquarters, they were telephoned to the owner of the store, who filled the orders and wrote the baby's name and address on each bag. When a number of orders were ready, the Red Cross Transportation Department called for the bags and delivered them to the babies by truck or by boat. This was a great help, as the parents in the inundated districts were not permitted on the streets because of the restrictions of martial law. Public health nurses also helped deliver powdered milk.

You don't realize how a flood can change things until you are actually in the midst of one. We were so thankful that we could have military control. Everything you do takes so long—in fact about twice as long as usually. All eating places are so crowded we had to stand in line and wait. Then we ate from paper dishes. Good drinking water is better than ice cream sodas, which we had to substitute because the water was unsafe to drink unless it was boiled! And getting around by boat is very slow and inconvenient.

On January 26 and 27 the pediatricians were not available for our west and east baby conferences. However, milk was dispensed by the nurse at both places and also at the colored clinic on Friday, January 29. On February 2 and 3 one pediatrician was in attendance at the west clinic and one at the east clinic. All other clinics were postponed.

After restrictions were removed, during the week of February 8, normal Health Center activities, including all clinics, were again resumed. Our office group served wherever possible, and began its regular duties as soon as the Health Center was opened after a great

A scene repeated many times over in the recent floods of the Mid-west—a nurse disembarking from a boat to visit a patient

Courtesy American Red Cross

deal of preliminary work, such as getting a permit to open the center, having plumbing repairs made, and getting a physician's certificate as to sanitation.

NURSING SERVICE

Despite the fact that thirteen nurses of our staff were engaged in Red Cross duty for periods of varying lengths, two nurses were ill, and one was off duty with a fractured arm, every call that came to our temporary headquarters was answered. Most of the thirteen nurses helped in the local flood disaster. Seven were sent to the following towns: Tell City, Mt. Vernon, and Rockport, Indiana; and Lewisport, Morganfield, and Princeton, Kentucky.

The other six nurses traveling in various ways—by truck, automobile, boat, ambulance, or by foot in hip-boots—answered the emergency calls of the Public Health Nursing Association as well as continuing the most necessary nursing care to newborn babies and to certain chronic patients who could not be deserted, and giving typhoid fever inoculations in inundated areas.

All of our staff nurses were released from Red Cross duty by February 15, except one who was retained by special request in the Red Cross flood relief office here. We realized that this work could best be continued by one who is familiar with the territory of the county involved, and with the local problems.

During the period following, the additional work of flood relief, typhoid fever inoculations, and bedside nursing was done efficiently in the county by three additional Red Cross nurses, together with our own county nurse, under the supervision of the Public Health Nursing Association nurse who was retained by the Red Cross flood relief office. The Red Cross also added a public health nurse to assist with general flood relief work on our Association staff.

We appreciate the work of the Red Cross very much, to say the least. Our organization is most happy to have released its public health nurses to the Red Cross to help serve during the most urgent period of distress, caused by the flood in our community. The Red Cross, on its part, has expressed appreciation for the coöperation of our organization and the work of our nurses.

YEARLY REVIEW STUDY

Last year we sent out our usual questionnaire entitled, "Yearly Review," the replies to which give us a basis for our annual study of what has happened in the field of public health nursing for the previous year. The last such study published referred to the year 1934, and appeared in the October 1935 issue of PUBLIC HEALTH NURSING.* Due to limitations of staff, the data furnished for 1935 have not been analyzed, and since it is almost time for a study of 1936, they will not be.

However, we want you to know that the information is available. You may want to know, for example, what arrangements other agencies have in regard to income from tax funds, how they are using volunteers, how much nursing time they lost on account of sick leave, their visit and case figures and how they were distributed among the various services, or the results of recent time-distribution studies. We have the answers to these questions and will be glad to prepare them for you, on request.

*"Our Annual Inventory." PUBLIC HEALTH NURSING, October 1935.

Forms for Reporting School Health Service

By ANNA J. MILLER
Statistician, National Organization for Public Health Nursing

The forms presented here are intended for the monthly and annual tabulation of school health services. The items are not limited to nursing service, but attempt to include all aspects of the school health service which can be reported statistically

THIS OUTLINE* supplements the tabulation of items recommended for inclusion in monthly and annual reports by the Records Committee of the National Organization for Public Health Nursing, and published in the June 1935 issue of PUBLIC HEALTH NURSING. It is intended for use by agencies (boards of education, health departments, public health nursing organizations, etc.), in which public health nursing service to school children is organized in close relationship to the program of health examinations and inspection of children in the school building.

The Education Committee of the School Nursing Section* realizes that this material is not entirely satisfactory, and has certain modifications under consideration. However, it is felt that even in tentative form it is more adequate than such material now available from the N.O.P.H.N. and it is being published here so that it can be referred to by those contemplating a change in their own forms at the beginning of the next school year. An effort has been made to make it conform with Section F, School Hygiene, of the "Tabulation of Health Department Services," approved in 1936 by the State and Territorial Health Officers, the U. S. Public Health Service, and the U. S. Children's Bureau.*

Revisions which have been suggested but which are not sufficiently developed to be included in this preliminary outline are:

The addition of items to indicate quality of health service, to supplement items now included which measure quantity of the service.

The addition of items relative to sanitation of school buildings.

The committee will be glad to receive any comments and suggestions so that they can be considered in connection with the revision which is contemplated.

Tabulations I and II include items which the committee feels are essential in an annual report of school health service. The items in Tabulation I should be recorded monthly, those in Tabulation II only once, at the end of the year. Those items on which a daily count can be kept and recorded readily are included in Tabulation I. The items in Tabulation II include such general information as schools and school population served, etc., and also those items which can be tabulated more easily and to greater advantage from the individual case records at the end of the reporting year, rather than daily.

In Tabulation I three columns are provided for, one for "Total this month," one for "Total to date this year," and the third for "Total to date

*Prepared by the N.O.P.H.N. Education Committee of the School Nursing Section, which now functions as the Subcommittee on School Nursing Records of the Records Committee. Approved by the Subcommittee on Manual of Practice of the American Public Health Association Committee on Administrative Practice.

*Tabulation of Health Department Services, Reprint No. 1768, from the U. S. Public Health Reports, Vol. 51, No. 36, September 4, 1936, Government Printing Office, Washington, D. C., 1936.

last year." An entry in the second column for a given item is a cumulative total and will be the entry in the first column plus the corresponding figure shown in the column "Total to date this year" for the given item in the report for the previous month. The figures shown in this column for the last month of the reporting year are the annual totals. The third column is useful for comparing totals this year with the corresponding period of the preceding year.

SCHOOL HEALTH SERVICE

TABULATION 1

(Monthly)

Department ..... City ..... State ..... Month ..... Year.....

	Total this month	Total to date this year	Total to date last year
A. EXAMINATIONS			
1. Number of examinations by physicians..... Examination defined as a formal examination at stated periods to determine physical status.*	.....	.....	.....
2. Number at which nurse assisted.....	.....	.....	.....
3. Number with parents present.....	.....	.....	.....
B. INSPECTIONS			
1. Number of inspections by nurse..... Include inspections by nurse where there is no physician on the staff; also such inspections as are made by the nurse at stated periods and are more complete than inspections for a special condition. Inspections and tests for a special condition are recorded in items B 3 through 30.	.....	.....	.....
2. Number with parents present..... Items B 3 through 30, which follow, include also the inspections and tests given as part of the more complete inspections enumerated in item B 1.	.....	.....	.....
3. Number for detection of communicable disease: by physician	.....	.....	.....
4. by nurse	.....	.....	.....
5. Number for personal hygiene: by physician	.....	.....	.....
6. by nurse	.....	.....	.....
7. Number for check on correction of physical defects: by physician	.....	.....	.....
8. by nurse	.....	.....	.....
9. Visual acuity tests: by physician	.....	.....	.....
10. by nurse	.....	.....	.....
11. by teacher	.....	.....	.....
12. Other eye tests (specify): by physician	.....	.....	.....
13. by nurse	.....	.....	.....
14. Eye inspections: by physician	.....	.....	.....
15. by nurse	.....	.....	.....
16. by teacher	.....	.....	.....
17. Hearing tests: by physician	.....	.....	.....
18. by nurse	.....	.....	.....
19. by teacher	.....	.....	.....

*Health examination is defined in the Appraisal Form for City Health Work, prepared by the Committee on Administration Practice of the American Public Health Association, 50 West 50 Street, New York, N. Y. Fourth edition, 1934. Page 99, item 38ai.

B. INSPECTIONS—Cont.		Total this month	Total to date this year	Total to date last year
20. Ear inspections:	by physician			
21.	by nurse			
22. Dental inspections:	by dentist			
23.	by dental hygienist			
24.	by nurse			
25. Height-weight measurements:**	by teacher			
26.	by nurse			
27.	by physician			
28. Number of these which showed gain in weight				
29. Number of these which showed loss in weight				
30. Other inspections or tests (specify)				

C. DISMISSALS OR EXCLUSIONS	Total this month	Total to date this year	Total to date last year
1. Pupils recommended for dismissal or exclusion for suspected communicable disease			
2. Other reasons			

D. CONFERENCES BY NURSES***	Total this month	Total to date this year	Total to date last year
1. In the home			
2. In the school with principals and teachers			
3. with parents			
4. with pupils (include those not covered in inspection items, section B)			
5. Other nurse conferences (specify)			

E. EDUCATIONAL

1. Organized health instruction given by nurses.
   Since the details on this question do not usually change from month to month within a school semester they need not be entered each month but only for the first month of each term, unless changes occur at other intervals.

Grades in which given	Title of course	Given during or outside of school hours	No. of periods per week	Length of period	Credits allowed	No. of classes	Total enrollment in these classes
						Total	

**Include also weighings when height is not measured.

***The most recent recommendation of the N.O.P.H.N. Records Committee defining the nursing visit and the procedure relative to count is as follows:

A visit is a contact made in a professional capacity by a qualified member of the staff to or in behalf of a case (meaning a condition of disease or health) or to or in behalf of a special activity. Visits may be made either in the field or in the office of the agency and should be noted on a specific record form.

Office visits should include visits by or in behalf of cases under care in which the same type

E. EDUCATIONAL—Cont.		Total this month	Total to date this year	Total to date last year
2. Nurse participation in classroom health instruction program through supplementary talks:	number			
3.	attendance			
4. Nurse participation in parent-teacher health program through talks:	number			
5.	attendance			
6. Other participation in the school health educational program (specify)				

F. OTHER ACTIVITIES NOT INCLUDED ABOVE (specify)

SCHOOL HEALTH SERVICE

TABULATION II

Items for annual report in addition to those shown in Monthly Tabulation I.

1. List schools under supervision, identifying by district, and show enrollment of each.

Name or number of school	Enrollment

Total number of schools ..... Total enrollment .....

2. Staff

	Number	Full time No. of months	Part time Number	Part time Hours of service per week
Physicians				
Nurses			*	*
Dentists				
Dental hygienists				
Other (specify)...				

3. Time distribution of nursing staff

Routine time studies are not to be kept, but special studies should be made for a definite period at different intervals. These details may be omitted when school nursing service is given by generalized nurses.

	Proportion of time given
a. In school (excluding 3d and 3e)	
b. In home	
c. In travel	
d. In classes	
e. In clinics	

---

of individual service was rendered by the nurse as would have been given in a field visit.

The visits to be counted in reporting or analyzing the work of an agency are those which meet the definition and for which an entry concerning the service has been made on some formal record of the organization.

Entries are to be made on the case record when a definite service has been rendered to the individual under care. Inquiry about the health of the individual under care or advice informally given, or errands, should not be counted as a visit.

4. Number of children examined, number found with defects, and number with defect corrected or under treatment:

	No. of children examined	No. of children found with defect**	% of children examined found with defect**	No. of children with defect corrected or under treatment by private physician or clinic
a. Eyes				
b. Vision				
c. Ears				
d. Hearing				
e. Teeth				
f. Gums				
g. Nasal passages				
h. Throat				
i. Skin and scalp				
j. Speech defect				
k. Nervous symptoms				
l. Lymph nodes				
m. Thyroid				
n. Heart				
o. Lungs				
p. Orthopedic				
q. Crippled				
r. Nutrition				

5. Number of children referred to parents for medical service .....

6. Number of children referred to parents for dental service .....

7. Number of children referred to coöperating agencies outside the school .....

*Include here specialized school nurses employed part-time and also generalized nurses giving part of their time to school nursing service.

**An analysis of these figures to indicate the number of years a notation of the given defect has been noted on the case record will be of significance in any study of efficiency of the school health program in accomplishing corrections.

In order to have the monthly totals for each item available at the end of the month for the entire service, the monthly totals for each item for each nurse will be required. Obviously, therefore, each nurse will need a form on which to record her daily activities. Such a work sheet would carry, on the left, a list of the items to be recorded (this list corresponding to the list in the monthly report form given in Tabulation I), with columns on the right provided for entry of daily totals. Several arrangements are possible. A work sheet is illustrated on page 320 for entering the daily totals for each item for each day of the month, for a given school. This work sheet can be modified to meet the requirements of different situations. If, for example, several schools are visited during the month, additional space can be provided for entering the number or name of the school visited on a given day, directly below the "Date" line.

WORK SHEET

MONTHLY TABULATION OF SCHOOL HEALTH SERVICE

Nurse_____ School_____ Department_____ City_____ State_____ Month_____ 19___

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total
A 1. Examinations by physicians																																
2. Number at which nurse assisted																																
3. Number with parents present																																
B 1. Inspections by nurse																																
2. Number with parents present																																
3. Inspections for detection of communicable disease: by physician																																
4. by nurse																																
5. Inspections for personal hygiene: by physician																																
6. by nurse																																
7. Inspections for check on correction of physical defects: by physician																																
8. by nurse																																
9. Visual acuity tests: by physician																																
10. by nurse																																
11. by teacher																																
12. Other eye tests: by physician																																
13. by nurse																																
14. Eye inspections: by physician																																
15. by nurse																																
16. by teacher																																
17. Hearing tests: by physician																																
18. by nurse																																
19. by teacher																																
20. Ear inspections: by physician																																
21. by nurse																																
22. Dental inspections: by dentist																																
23. by dental hygienist																																
24. by nurse																																
25. Height-weight measurements: by teacher																																
26. by nurse																																
27. by physician																																
28. Number showing: gain in weight																																
29. loss in weight																																
30. Other inspections or tests (Specify)																																
C 1. Pupils recommended for treatment or exclusion for suspected communicable disease																																
2. other reasons																																
D 1. Nurse conferences in the home																																
2. Nurse conferences in school: with principals, teachers																																
3. with parents																																
4. with pupils																																
5. Other nurse conferences (Specify)																																
E* 2. Classroom health talks: number																																
3. attendance																																
4. Parent-teacher talks: number																																
5. attendance																																
6. Other participation in school health education program (Specify)																																
F Other activities (Specify)																																

* Item E 1 omitted as it is not tabulated monthly

Work sheet for use by individual nurse for daily entries of totals required for items on monthly report form I, shown on pages 316-318

Each month hereafter we shall publish a list of articles that have appeared in the previous issue, which are available in reprint form. For a list of those in the March and April numbers turn to page 10

How Would You Answer This?

An obstetric reference library will be given by the Maternity Center Association to the nurse who most satisfactorily answers this month's question.

It is of course recognized that there is no definite and positive answer to a question of this kind. Any decision is necessarily based on existing measuring rods which have been worked out on the basis of needs and services in typical communities.

Some of these criteria are frankly set as minimum standards—such as those given in Dr. Ira V. Hiscock's book *Community Health Organization.** Others represent a reasonable standard of service—such as the standard for maternity visits in the *Manual of Public Health Nursing.*** The important thing is, of course, that every public health nursing program should be *planned* so that each service is given its proper share of attention in relation to the particular needs in that community, rather than being administered in hit-or-miss fashion.

A committee from the Maternity and Child Health Council of the National Organization for Public Health Nursing will make the decision, which will be published in July—unless the committee is so overwhelmed with entries that the decision has to be held over the vacation period!

Send your replies to the Maternity Center Association, 1 East 57 Street, New York, N. Y.

If you were responsible for directing the work of 14 visiting nurses in the community described below, how much time would you devote to maternity service and what would that service include? Tell how you arrived at your decision.

The community is urban and has a population of 30,000. There is no real poverty. There were 500 births last year, 300 in hospitals and 200 at home. There are 3150 preschool children and 4500 school children. Last year it required 11,000 nursing visits to give bedside care to the sick in the homes, exclusive of visits to obstetric patients. There is no other community nursing service except that provided by private duty nurses.

*Published by The Commonwealth Fund, New York, 1932.

**National Organization for Public Health Nursing. Manual of Public Health Nursing. The Macmillan Company, New York, 1932.

REFERENCES ON MATERNITY

This bibliography does not include all the good books on this subject, nor does it include important books on those diseases which often complicate pregnancy such as syphilis, tuberculosis, diabetes, and heart disease. A knowledge of these diseases in relation to maternity is essential to good obstetric nursing.

Beck, Alfred C. Obstetrical Practice. 702 pages. Williams and Wilkins Company, Baltimore, 1935. $7.00.

A standard medical text for reference use.

Butterfield, Oliver M. Marriage. 40 pages. Emerson Books, New York, 1934. 50c.

A pamphlet on the marriage relationship, simply written for the average uninstructed young couple.

De Lee, Joseph B. Obstetrics for Nurses. 10th revised edition. 666 pages. W B. Saunders Company, Philadelphia, 1933. $2.75.

A well known textbook written for nurses by a doctor. A clear presentation of what an obstetrician expects of a nurse in the way of performance and information.

Gavit, John P. "Some Inf'mation for Mothers." 16 pages. American Social Hygiene Association, 50 West 50th Street, New York, 1935. 10c.

A delightful story of a fisherman's answers to a little girl's questions about eggs and babies. Helpful in giving mothers an idea of how to answer their children's first questions about how babies come.

Guttmacher, Alan, and Kohn, Rosa. Life in the Making. 297 pages. The Viking Press, New York, 1933. $3.75. 1935 reprint edi-

tion by the Garden City Publishing Co., New York. $1.00.

An absorbing story that traces the history of man's beliefs about the origin of life from ancient superstitions to the scientific knowledge of today.

Kenyon, Josephine H. Healthy Babies are Happy Babies. 321 pages. Little, Brown and Company, Boston, 1934. $1.50.

A delightfully written book on the development and care of the baby through the third year with one chapter on the preparations before and during pregnancy.

Maternity Center Association. Maternity Handbook for Pregnant Mothers and Expectant Fathers. 178 pages. G. P. Putnam's Sons, New York, 1932. $1.00

Presents in the simplest language the fundamentals of mother and baby care as they are taught by the Maternity Center Association. Well illustrated.

Maternity Center Association. Routines. Fourth revised edition. 84 pages. New York, 1935. 50c.

A well illustrated booklet of obstetric techniques in public health nursing and the briefs for a series of classes for mothers.

Stone, Abraham, and Hannah M. A Marriage Manual. 334 pages. Simon and Shuster, New York, 1935. $2.50.

A book of sound and authentic information, written for the layman.

Strain, Frances B. Being Born. 144 pages. D. Appleton-Century Company, New York, 1936. $1.50.

A simple book about sex and reproduction written for children. A good book for the mother who wants to teach her children about their origin and growth.

Strain, Frances B. New Patterns in Sex Teaching. 242 pages. D. Appleton-Century Company, New York, 1934. $2.00.

A simple presentation of the reasons for teaching children about sex, and a discussion of the best methods to use from infancy to adolescence.

Van Blarcom, Carolyn. Obstetrical Nursing. Third revised edition. 651 pages. The Macmillan Company, New York, 1933. $3.00.

A scholarly text by a nurse emphasizing the need, value, and enduring satisfactions of good obstetric nursing. The different techniques used throughout the country are discussed as well as the fundamental obstetrics essential to an intelligent understanding of the nursing procedures.

White House Conference. Obstetric Education. 302 pages. D. Appleton-Century Company, New York, 1932. $3.00.

Contains the report and recommendations of the committee that studied the teaching of obstetric nursing and the graduate nurse's knowledge of obstetrics.

Williams, J. Whitridge. Obstetrics. Seventh edition revised by Henricus J. Stander. 1269 pages. D. Appleton-Century Company, New York, 1936. $10.00.

A standard medical text for reference use.

Zabriskie, Louise. Nurse's Handbook of Obstetrics. Fourth revised edition. 537 pages. J. B. Lippincott Company, Philadelphia, 1934. $3.00.

A textbook by a nurse with emphasis on the nursing care of the mother and baby in the home. Excellent illustrations.

U. S. Children's Bureau. Comparability of Maternal Mortality Rates in the United States and Certain Foreign Countries, by Elizabeth C. Tandy. 24 pages. Superintendent of Documents, Washington, D. C., 1935. 5c.

A clear discussion of the factors to be considered in comparing the maternal mortality rates of the United States and other countries where statistical methods differ.

U. S. Children's Bureau. Maternal Mortality in Fifteen States. 215 pages. Superintendent of Documents, Washington, D. C., 1934. 20c.

A report of the findings of a study of the maternal care and the circumstances surrounding the deaths of 7537 mothers in 15 states in 1927 and 1928, with discussion of the causes of the deaths.

Nurse-of-the-Month

MARGARET M. MERRICK
Illinois

Miss Merrick was born in Spring Valley, Illinois, and was educated in Peru and La Salle. Her three-year nursing course was finished at Ryburn Memorial Hospital, Ottawa, Illinois, in 1919, with affiliations at Durand Hospital, Chicago, Illinois, and Chicago Lying-In Hospital. She did private-duty nursing for several years, and held positions as general supervisor at the Isolation Hospital, Peru, night supervisor at Victory Memorial Hospital, Waukegan, and obstetrical supervisor at St. Margaret's Hospital, Spring Valley—all in Illinois.

For twelve years she has been connected with the Hygienic Institute—which is the name of the health department for three small towns with headquarters at La Salle, Illinois—as one of the staff nurses doing generalized nursing. Her area is entirely industrial, with a cosmopolitan population, representing a cross section of many European nationalities.

The Hygienic Institute is unique in that it is an endowed health department serving the cities of La Salle, Peru, and Oglesby, Illinois, as an official agency. It was organized in 1914. The endowment covers about 70 percent of the maintenance. The nursing service is generalized and includes public and parochial school nursing, maternity, infant, preschool, and tuberculosis nursing, and bedside care.

Unsolicited comments from the files and remarks that have come to the office by word of mouth furnish material to picture the many facets of Miss Merrick's ever-changing work:

PHYSICIAN WHO FREQUENTLY CALLS UPON THE NURSING SERVICE: I welcome the nurse's visits to my prenatals and infants—I call her frequently for demonstration of care for the newborn. The nurse is valuable to me on discharged hospital cases and I trust her to do any surgical dressing that I would do myself in the home. The nurse can do more for the people who have tuberculosis than I can. I call her for follow-up care on all my families who will welcome her visit no matter what the financial standing may be. My own children, too, are affected and influenced by the stimulation given at school, to care for their health, to have immunization done agreeably, and for corrections—especially of teeth.

PRESIDENT, JANE DELANO CLUB (membership requirement is certificate of completion of course in home hygiene and care of the sick): None of us realized what the health department meant in our town until we had this course and the health work was interpreted to us so we could understand it. Nearly everyone of us carried on a project of special importance to ourselves or our home, and I believe everyone profited in some

way. Everything from chronic constipation to poor mental attitudes was corrected. A kindred feeling has been built between us and the health department. We try to show our appreciation in various ways. At present we are raising a fund for x-ray pictures for our school children.

AN ELDERLY, WEALTHY WOMAN HAVING PAY-NURSING SERVICE: It means a great deal to me to have the nurse come for my care three times a week. I would otherwise be in a hospital. This way, my home life goes on and I feel that the nurse is my friend and visitor.

PRESIDENT OF COUNTY FEDERATED WOMEN'S CLUBS: Our community consciousness has been stimulated by the nurse, who presents her problems at our evening meetings. One of our clubs has provided dental care to a certain group; another layettes; a third, glasses for needy children. The "Little Women" sponsor an annual mother's party.

FAMILY CASE WORKER AND PROBATION OFFICER: Every type of social problem is seen by the nurse. Her visits include all age-groups and she knows every member of the family. She is sensitive to social conditions because of her training and experience. The nurse is our key person from whom to expect encouragement and supervision with the children having special problems, who are returned to their homes and to school. Her work and mine dovetail in promoting the general health of our pension cases and their children.

PERSONNEL MANAGER OF A LARGE INDUSTRY: My company is particularly interested in keeping its men happy and in good health. The nurse knows our employees' families. Her work is of tremendous assistance to us in our efforts to improve the living conditions of our men. She gives nursing service and supervision to those families having tuberculosis. I have seen the value of the nursing service through personal experience as well. The nurse was very helpful when my wife returned from the hospital with our first little girl. The boys are in school and our home teaching is emphasized by her there.

PSYCHIATRIC SOCIAL WORKER, HIGH SCHOOL: The children entering high school are prepared for their physical examination by the nurse. She has helped to safeguard their health through the grades. Her school cards, which contain valuable information, come to me for use during the next four years. I often call on the nursing service for conference on special problems.

CHAIRMAN, SERVICE COMMITTEE, ELKS' CLUB: Our club has financed the care of crippled children for years. I can cite an instance where the nurse's care resulted in the early attention to a baby born with clubfeet. This might have been cared for later on, but our orthopedic surgeon tells me the earlier he gets such patients, the better. When this little fellow learned to walk, he walked like any normal child. Babies with birth paralysis have been brought in by the nurse. She follows up these cases and demonstrates their care to the mothers. Without the nurse's work we would be handicapped in reaching many of these needy families. She finds them, and we furnish the money for their care.

PRESIDENT, BOARD OF EDUCATION: As a father I feel safe in sending my children to school even during an epidemic. The nurse is watchful and coöperates with the teachers in the health supervision of the children. The health cabinets are a splendid device to keep children interested in improving their health.

HIGH SCHOOL GIRL, GIVEN NURSING CARE: In my second year at high school I was very ill with nephritis. My stepfather and brothers were unable to give

the necessary care. My doctor called the nurse for my hot packs. When I began to get well I found her a source of encouragement and strength to gain a new outlook on life. She gave me small tasks to do until I gained in health. When I was well again, she helped me to find employment.

WIFE OF MAN WHO HAS TUBERCULOSIS (FOREIGN-BORN): My man go to the sanatorium with the nurse. Me and my baby go to the baby health conference. The nurse comes to my house lots. She sends me to the doctor so I don't get sick. I try to eat right and sleep lots and go out in sun and never get sick like my man. The nurse, she sees my man at the sanatorium and talks to him and makes him happy.

EXECUTIVE IN A LARGE INDUSTRY: I am not speaking for the company now, but for my own family. My children are seen by specialists in preparation for school. We never thought of having a vision test given to them, however. Last autumn my boy was among the children tested in school and much to our surprise the nurse stated that although his vision test was normal he showed symptoms of eyestrain. We took him to an oculist who confirmed her findings. Where before we could not account for his indifference and behavior at home and at school, he returned to normal behavior after the suggested corrections had been made.

THE HEALTH OFFICER: Statistics are dry and uninteresting, but seen in retrospect we can measure the full value of our effort. Each does her part in the control of communicable disease. A comparison of the past ten-year period with a ten-year period just preceding it when there was no organized nursing program, discloses the fact that we have tripled the number of cases of communicable disease discovered and quarantined, and the death rate has been reduced many times. The cases of scarlet fever placed on record, for instance, have been increased three times; but the death rate has been reduced seven times, or to one third of that of the State. Diphtheria has been reduced twenty times in case incidence, and seventy times in mortality rate—in fact almost to nothing. While the mortality from measles and whooping cough has been much less affected, we certainly have discovered and placed on record double and triple the number of cases. Our immunization for smallpox has jumped from five percent of the population to ninety percent and that of diphtheria from none to sixty-five percent. I do believe that the intensive and early case finding of communicable disease by the nurse and its early isolation and quarantine has an effect on the mortality rate.

THE AMERICAN JOURNAL OF NURSING FOR MAY

The new N.O.P.H.N. poster, "Welcoming the Nurse," is described on page 4.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

NEW YORK CITY WISHES US "MANY HAPPY RETURNS"

The ballroom of the Roosevelt Hotel on a sunny Spring day in March was crowded to its doors with members and friends of the N.O.P.H.N. who had come to give us birthday greetings and wish us well as we go forward into the next quarter-century of service to public health nursing. Seven hundred and forty diners listened to the delightfully informal welcome from the presiding officer, Charles C. Burlingham, and then applauded as Miss Grant gave a brief explanation of the purpose and aims of our Silver Jubilee Year. Elizabeth G. Fox, a former president of the N.O.P.H.N., and now director of the New Haven Visiting Nurse Association, presented a stirring picture of our past history and called for support and understanding from everyone in the challenges which face the N.O.P.H.N. in the coming years. Her address appears on page 275.

Dr. Livingston Farrand, a member of the N.O.P.H.N. Advisory Council and for many years a wise friend and guide to all public health nurses, delivered his message over a nation-wide radio hookup (see page 273) and we know his words reached many of our absent members.

Two nurses dressed in the uniforms of 1912 and 1937 were presented to the audience. Lulu St. Clair, Executive Secretary, Joint Committee on Community Nursing, took the part of the 1912 nurse; Henrietta Hoffman, of the Henry Street Visiting Nurse Service, New York City, was the modern nurse. (See page 291.)

Not the least enjoyable part of the luncheon were the telegrams and letters which came from old friends and new. Our honorary presidents, Lillian D. Wald and Mary S. Gardner, sent affectionate greetings. Dr. C.-E. A. Winslow, Senator T. F. Green, Lavinia Dock, and Marguerite Wales were among others who conveyed birthday wishes to us, and Mrs. Franklin D. Roosevelt's contribution came in just in time to open the New York City campaign for funds.

Best of all, so the staff felt, was the presence on the platform of our first executive director, Ella Phillips Crandall. She looked and spoke as though she had left her desk in the N.O.P.H.N but yesterday and if you had been near her you would have noticed almost every sentence starting with, "Will you ever forget the day," or "Do you remember the time"—and then gales of laughter. Some of us listened a little wistfully wondering if they ever used to worry about the budget in the early days.

A group of about 200 board members from visiting nurse associations in New York and nearby states participated in the round table for board members, under the able leadership of Mrs. Morris Hadley.

Mrs. Arthur Marsters, President of the Visiting Nurse Association, Morristown, New Jersey, outlined the plans for the N.O.P.H.N. Silver Jubilee celebration, emphasizing the importance of the support of the N.O.P.H.N. by lay people, who are vitally concerned with high standards of nursing care for their communities.

Dr. Estella Ford Warner, Surgeon General of the United States Public Health Service, discussed the way in which the private agency fits into the Social Security program, and stressed the need for an active interest on the part of lay boards of voluntary agencies

in seeing that high standards are maintained in the public health programs under the Social Security Act.

Dorothy Deming, General Director of the N.O.P.H.N., discussed the work of the N.O.P.H.N. Pension Committee in studying various retirement plans. She reported that questionnaires had been sent out recently to N.O.P.H.N. member agencies concerning the question of whether it is desirable for staffs of philanthropic agencies to be included under the provisions of the Social Security Act. The returns so far are incomplete and show considerable difference of opinion on the question. Miss Deming pointed out the need of some type of retirement plan for nurses in voluntary agencies.

Dorothy Roberts, Mental Hygiene Consultant of the Visiting Nurse Association of New Haven, Connecticut, described the activities, selection, and training of the 300 volunteers enrolled in that organization, of which 85 are in active service all the time. She pointed out that the use of volunteers constitutes a contribution of $12,000 a year to the agency.

Mrs. Shephard Krech, President of Maternity Center Association, New York City, reported on a recent professional conference on the positive aspects of eugenics. She stressed the need for financing maternity care for families of the middle class so that they can afford to have larger families; and the need for premarital clinics to give consultation service on problems related to marriage.

The public health nurses under Amelia Grant's capable leadership discussed the nurse's part in a program for the control of syphilis and gonorrhea. The subject was discussed from the standpoint of a maternity nurse by Hattie Hemschmeyer, Assistant Director, Maternity Center Association, New York City; from the standpoint of the infant and preschool service by Mary Bond, Director, Central Bergen Visiting Nurse Service, Hackensack, New Jersey; from the standpoint of the school nurse by Lula P. Dilworth, Associate in Health and Safety Education, State Department of Public Instruction, Trenton, New Jersey; and from the standpoint of an adult health service by Anne McCabe, Director, Division of Public Health Nursing, County Health Department, White Plains, New York.

The discussion brought out that any nurse—whether in a generalized or specialized service—who comes in contact with the family in the home has a contribution to make to the program for the control of these diseases.

A representative of one community reported that a local woman's organization has undertaken as a year's health project that each member will voluntarily secure a Wassermann test within the year in an effort to take leadership in eradicating the stigma which has been attached to syphilis in the past.

Mrs. Katherine Orbison, Director, Visiting Nurse Association, New Rochelle, New York, discussed a study being made in Westchester County, New York, on the feasibility of furnishing visiting nurse service on an insurance plan similar to that of the group hospital plan. It is hoped that the study will show how much additional service would be required from the agencies in the county and what would be the probable cost. Mrs. Orbison said the study had brought out so far that many people in the higher economic levels want some type of visiting nursing care; that there is a great demand for visiting housekeepers; and that there would be a decrease of patients' time in hospitals and a release of hospital beds if visiting nursing service were available to all groups.

The hands of the Roosevelt clock stood at six, as the last diners called it a day and went home.

The New York Committee is to be congratulated on having engineered such a very successful opening birthday for the N O.P.H.N.

WITH THE STAFF

Dorothy Deming, General Director of the N.O.P.H.N., is first on the list of a general exodus of executives for field trips covering almost two thirds of the United States and going as far as Canada. On April 19, Miss Deming went to Greenwich, Conn., to speak at a meeting of the Council of Social Agencies, and on the 22nd to Cincinnati, Ohio, where she spoke on the N.O.P.H.N.'s Silver Jubilee celebration at the Annual Meeting of the State Nurses' Association. Her plans for a longer trip in May will take her still farther into the Midwest and Southwest.

Evelyn Davis led a discussion group at the meeting of the National Federation of Day Nurseries at the Commodore Hotel in New York City on April 9. On April 12 and 13 she conducted a board members' institute of the District Nursing Association at Middletown, Conn. From there she went to Ottawa, Canada, to be a guest speaker at the 39th annual meeting of the Victorian Order of Nurses on April 14 and 15. She then returned to New York before going to Moorestown, N. J., to represent the N.O.P.H.N. at a regional Jubilee celebration. On April 23, she met with the board and committee members of the Visiting Nurse Association of East Chicago, Ind., and on the 28th she led a board members' conference under the auspices of the Council of Social Agencies in Chicago, Ill.

Early in April, Ella McNeil visited the following school nursing services: Audubon, N. J., Beacon, N. Y., Boston, Brookline, and Springfield, Mass., and Hartford, Conn. After returning to the office until April 15, she went to Cleveland, Ohio; from there to South Bend, Ind., April 19; to St. Louis, Mo., April 21-23; to Des Moines, Iowa, April 26-27; and from there to Springfield, Mo., where she spoke at the annual meeting of the Missouri Public Health Association.

Virginia Jones visited the public health nursing course at the University of Michigan, at Ann Arbor, March 22-23. Going to Detroit, Mich., on March 31, she visited the teaching centers of the Visiting Nurse Association and the Department of Health, and the social hygiene clinic of the Health Department. She attended the Midwest Supervisors' Conference at Cleveland, Ohio, April 2-3; and made advisory visits to new courses at the University of Indiana, Bloomington, March 25-27, Ohio State University, Columbus, April 5-6, and Duquesne University, Pittsburgh, Pa., April 7.

STATE LAY JUBILEE CHAIRMEN

To assist with the Silver Jubilee celebration of the N.O.P.H.N., a lay person is being appointed in each state to serve with our Silver Jubilee Committee. Through this key person our Jubilee plans and activities are being coördinated. Already twenty-six states under the leadership of the chairmen listed below have begun to make their plans.

California—Mrs. Ruth Close, Redwood City
Colorado—Mrs. Robert Bosworth, Denver
Connecticut—Mrs. A. T. Enos, Jr., Greenwich
Delaware—Mrs. Donald P. Ross, Montchanin
District of Columbia—Mrs. Harlan Stone, Washington, D. C.
Georgia—Mrs. Frank McIntire, Savannah
Idaho—Mrs. Catherine Athey, Boise
Illinois—Mrs. W. Ashton Johnson, Rockford
Indiana—Mrs. Benjamin Hitz, Indianapolis
Maine—Mrs. Parker Poole, Cumberland Foreside
Massachusetts—Mrs. Frederick S. Dellenbaugh, Jr., Chestnut Hill
Michigan—Mrs. J. Milton Robb, Grosse Pointe
Minnesota—Mrs. Stuart W. Rider, Minneapolis
Montana—Mrs. J. H. Morrow, Moore
New Hampshire—Mrs. Elwyn Page, Concord
New Jersey—Mrs. Arthur A. Marsters, Morristown
North Dakota—Mrs. W F. Baillie, Fargo
Ohio—Mrs. Joseph Barker, Cincinnati
Oregon—Mrs. Sadie Orr Dunbar, Portland
Pennsylvania—Mr. Fred H. Ludwig, Reading
Rhode Island—Miss Virginia Ostby, Providence
South Dakota—Mrs. H. H. Holdridge, Madison
Tennessee—Mrs. Arch Trawick, Nashville
Vermont—Mrs. A. H. Rutter, Burlington
Washington—Miss Olive Kerry, Seattle
Wisconsin—Mrs. Stanley Stone, Milwaukee

SILVER JUBILEE HONOR ROLL

ARIZONA

****Yavapai Nurse Service, Prescott

CALIFORNIA

**County of Kern Health Department, Bakersfield
*****Visiting Nurses of San Diego, San Diego

COLORADO

*Adams County Nursing Service, Adams City
*Alamosa County Nursing Service, Alamosa
*Boulder County Nursing Service, Boulder
*Montezuma County Nursing Service, Cortez
*Rio Grande County Nursing Service, Del Norte
*Delta County Nursing Service, Delta
*****Colorado Tuberculosis Association, Denver
*****Metropolitan Life Insurance Nursing Service, Denver
*Durango Public School, Durango
*Arapahoe County Schools, Englewood
*Morgan County Nursing Service, Fort Morgan
*Jefferson County Nursing Service, Golden
**Greeley Public School, Greeley
*Grand County Nursing Service, Hot Sulphur Springs
*Lincoln County Nursing Service, Hugo
*Indian Reservation School of Ignacio, Ignacio
***Johnstown Public School, Johnstown
*Lamar Public School, Lamar
*Prowers County Nursing Service, Lamar
*Washington County Nursing Service, Pueblo
*Rio Blanco County Nursing Service, Rio Blanco
*Saguache County Nursing Service, Saguache
*Costilla County Nursing Service, San Luis
*Logan County Nursing Service, Sterling
*Maternity and Infancy Demonstration of Las Animas County, Trinidad
*Trinidad Public School, Trinidad

CONNECTICUT

**Visiting Nurse Association, Bridgeport
*Bridgeport Branch of Connecticut State Child Welfare Bureau, Bridgeport

FLORIDA

***Escambia County Health Department, Pensacola

GEORGIA

******Metropolitan Life Insurance Nursing Service, Atlanta
*Child Health Demonstration, State Department of Public Health, Sparta

ILLINOIS

*Goodman Manufacturing Company, Chicago
**Metropolitan Life Insurance Nursing Service, Chicago
**Visiting Nurse Association, Rockford
*Field Nursing Staff, Fairview Sanatorium, Normal

INDIANA

******Public Health Nursing Association, Evansville
****Red Cross Public Health Nursing Service, Fort Wayne
**Metropolitan Life Insurance Nursing Service, New Albany

IOWA

*Sioux City Health Department, Sioux City
*Public Schools, Sioux City

KENTUCKY

*****Public Health Center, Lexington

MASSACHUSETTS

***Emergency Nursing Association, Dedham
****Visiting Nurse Association, Quincy

MICHIGAN

******Public Health Nursing Service of the Civic League and Bay City, Bay City
*Ottawa County Health Department, Grand Haven
*Greater Lansing Visiting Nurse Association, Lansing

MINNESOTA

*Chippewa Indian Health Unit, Cass Lake
*St. Louis County Unit of the Arrowhead Health District, Duluth
*Division of Services for Crippled Children, State Board of Control, St. Paul
**Division of Child Hygiene, State Department of Health, Minneapolis

NEW HAMPSHIRE

*Board of Education, Rochester
***Visiting Nurse Association, Rochester

NEW JERSEY

*Metropolitan Life Insurance Nursing Service, Mount Holly
*****American Red Cross, Perth Amboy
**New Jersey State Department of Public Instruction, Trenton

NEW YORK

*Metropolitan Life Insurance Nursing Service, Beacon
**Metropolitan Life Insurance Nursing Service of Nassau County, Hempstead
***American Museum of Natural History, New York
******Joint Vocational Service, New York
*****National Society for the Prevention of Blindness, New York
****Neighborhood House, Tarrytown
**Visiting Nurse Association of Staten Island, Tompkinsville

NORTH DAKOTA

*City and School Public Health Nurse, Valley City

OHIO
*Visiting Nurse Association, Branch I, Cleveland

OKLAHOMA
******Public Health Association, Tulsa

PENNSYLVANIA
*****Henry Phipps Institute, Philadelphia
*****Negro Nursing Bureau, Philadelphia
*Metropolitan Life Insurance Nursing Service, Pottsville
***Visiting Nurse Association, Scranton

SOUTH DAKOTA
**Division of Public Health Nursing, Pierre

TENNESSEE
*****Department of Nursing Education, George Peabody College, Nashville

TEXAS
******Fort Worth-Tarrant County Tuberculosis Society, Fort Worth
******Department of Public Health and Welfare, Fort Worth

VERMONT
******Mutual Aid Association, Brattleboro

VIRGINIA
**Metropolitan Life Insurance Nursing Service, Portsmouth

WISCONSIN
*Visiting Nurse Association, Oshkosh

WYOMING
*State Department of Public Health, Cheyenne

HAWAII
***Palama Settlement, Honolulu

JOINT VOCATIONAL SERVICE

ADIEU, MISS KAHL!

announces with regret that F. Ruth Kahl resigned on April 1 to enter the government service, after serving for one year on a temporary appointment as Second Vocational Secretary for Public Health Nursing. Miss Kahl has accepted through civil service appointment the position of Consultant in Public Health Nursing for the Midwest area, United States Public Health Service. Her headquarters will be in Chicago. She succeeds Julia Groscop.

Miss Kahl is a native of Illinois, where she received her early academic and professional education. She later pursued her public health nursing education at Western Reserve University, Cleveland, Ohio, and received an A.B. degree at Hiram College, Hiram, Ohio. She has served as educational director of the Milwaukee Visiting Nurse Association and as field instructor in the University Nursing District in Cleveland, Ohio. She has engaged in health work for college students, and early in her career was child health nurse in Freeport, Illinois.

Congratulations to the U. S. Public Health Service and to Miss Kahl! She will be missed at J.V.S., where she made a real place for herself.

WELCOME, MISS FOSTER!

Mary Louise Foster has accepted an appointment as Assistant Vocational Secretary for Public Health Nursing and will come to J.V.S. in June at the close of the school year at Smith College, Northampton, Massachusetts, where she is health supervisor for students. Miss Foster is a graduate of the five-year nursing course of Simmons College affiliated with Massachusetts General Hospital School of Nursing, where she received her B.S. Degree and Public Health Nursing Certificate, and has had additional courses at Smith College and Massachusetts Institute of Technology. While her major experience has been in the eastern section of the country through three years each on the staff of the Visiting Nurse Association of New Haven, Connecticut, and at Smith College, she knows the Far West through experience in general community nursing under the American Red Cross at Fresno, California. Her "geographic merits" for the work of J.V.S. are further enhanced by her nativity in Nebraska.

Miss Foster's sound preparation and experience are combined with a very genuine interest in vocational counseling and employment service. Welcome, Miss Foster!

HIGH POINTS in SCHOOL HEALTH

A SCHOOL PROGRAM FOR EYE HEALTH

Physical Aspects

Part V

FAILURE OF EYES TO WORK TOGETHER

One or more conditions may be responsible for the failure of the two eyes to work together. Some of the most significant ones are:

1. Interference with the ability of the two eyes to work together may occur if there is a difference in the state of refraction of the two eyes.

2. At birth there may be imperfect vision in one eye.

3. There may be a deviation from normal of the muscles which control the movements of the eye, such as lack of muscle tone, defects in the size and insertion of the muscles, or a paralysis of the muscles of the eye.

4. The fusion faculty may be lacking or fail to develop perfectly.

5. Eye disease or injury may be responsible for the failure of the two eyes to work together.

One of the most frequent outward signs of failure of the two eyes to work together that is observed by the nurse in her inspection of children is strabismus, more commonly referred to as "cross-eyes." The nurse plays an important rôle in the treatment plan for children with this difficulty. She can impress upon parents the need for placing children under competent ophthalmological care at the first evidence of this condition, and, after the recommendations are made, can encourage parents to coöperate with the ophthalmologist in carrying out the recommended treatment. Dr. Luther Peter has outlined the several steps necessary to bring about results and to place the child with strabismus on an equal footing with other children. They are: testing of vision; fitting of glasses; preventing the lowering of vision in the weak eye; awakening of the fusion faculty; and finally, when necessary, operation.*

EYE DISEASES AND DEFECTS

Seriously impaired vision is usually the result of eye diseases or hereditary or congenital defects. Referring again to "The Causes of Blindness in Children,"** the causes are classified according to the part of the eye affected:

CAUSES OF BLINDNESS CLASSIFIED ACCORDING TO PART OF EYE AFFECTED

Cause of blindness	Percent
Eyeball	31.0
Cornea	14.4
Iris and ciliary body	2.2
Crystalline lens	17.1
Choroid and retina	14.4
Optic nerve	16.7
Vitreous humor	0.3
Miscellaneous and ill defined	3.9
	100.0

*Peter, Luther, M.D., "Facts and Fallacies Concerning Squint (Cross-Eye)." Reprinted from *The Sight-Saving Review*, September 1932. Publication 101, National Society for the Prevention of Blindness, 50 West 50 Street, New York, N. Y.

**Berens, Conrad, Kerby, C. E., and McKay, Evelyn C. "The Causes of Blindness in Children." *Journal of the American Medical Association*, 105:1949-1954, December 14, 1935.

It is impossible to include in this article more than a suggestion of the diseases and conditions which may affect various parts of the eye and seriously impair vision. Diagnoses of eye conditions of children attending sight-saving classes are worth noting. Some of these are: albinism, choroiditis, congenital cataract, corneal opacities as result of disease or injury, detached retina, interstitial keratitis, optic atrophy, phlyctenular keratitis, progressive myopia, and retinitis pigmentosa.

The nurse who understands the significance of eye difficulties has many opportunities for helping to prevent further loss of vision. In many instances she may be able to prevent their occurrence. Briefly this can be done by participating in programs to prevent eye diseases due to syphilis, tuberculosis, local infections of the eye, focal infections, and injuries.

The following table is taken in part from *Eye Health Primer for Nurses*:*

EXPLANATION OF SOME SERIOUS EYE CONDITIONS FOUND AMONG CHILDREN

Term	Part of eye involved	Cause	Explanatory notes
Choroiditis	Choroid	Most frequently caused by acquired or congenital syphilis, tuberculosis, and focal infections from oral and nasal cavities.	The choroid, a dark membrane, forms the middle coat of the eye and serves as an organ of nourishment for the other parts of the eye. Any disease of the choroid may affect the neighboring structures which are the retina, iris, optic nerve, vitreous, sclera, and lens.
Iritis	Iris. Iritis frequently involves the ciliary body and is then called Iridocyclitis.	Focal infections, syphilis, tuberculosis, gonorrhea, acute infectious diseases, diabetes, result of injury, cause not always known.	It is necessary to treat the underlying cause as well as the eye condition. If tuberculosis is the cause, injections of tuberculin are usually part of the treatment, as well as general treatment for tuberculosis. If syphilis is the cause, antiluetic treatment is advised. In the case of focal infections, removal of the cause of infection is part of the treatment plan. Vision may be greatly impaired.
Keratitis, phlyctenular	Cornea. If the conjunctiva only is affected it is then called phlyctenular conjunctivitis. If it occurs at the limbus (the place where the cornea and conjunctiva join) it is called phlyctenular kerato-conjunctivitis.	Tuberculosis and poor general health.	Tuberculosis is the most common cause; it usually occurs in children particularly those children whose general health is poor. Because ulcers form as a result of the inflammatory condition, vision may be impaired due to the resulting scars of the cornea.

Term	Part of Eye Involved	Cause	Explanatory Notes
Keratitis, interstitial	Cornea, but may also affect entire uveal tract.	Usually due to congenital syphilis. May be due to acquired syphilis.	Most frequently occurs before the age of 15. Vision is apt to be seriously impaired as the inflammatory process often leaves dense opacities of the cornea.
Optic atrophy	Optic nerve.	Primary optic atrophy may be due to syphilis, diabetes, affections of the brain. Secondary optic atrophy may be due to other eye diseases as glaucoma or retinitis choroiditis. It may be hereditary. Injury may also be a contributing factor.	In case of primary optic atrophy, blindness usually results. In secondary optic atrophy, there is a better prognosis. Vision may be impaired, but complete blindness may not result.
Retinitis	Retina, and usually extends to optic nerve and choroid.	May be primary or secondary with the following general causes: diabetes, syphilis, nephritis, trauma.	General treatment of the underlying cause is of greatest importance.
Uveitis	Iris, ciliary body and choroid.	Essentially the same as the causes of iritis.	Loss of vision or serious impairment are the rule rather than the exception.

*Francia Baird Crocker. "Eye Health Primer for Nurses." Reprinted from *The Sight-Saving Review*, March 1936. Publication 194. National Society for the Prevention of Blindness, 50 West 50 Street, New York.

FRANCIA BAIRD CROCKER, R.N.
Associate for Nursing Activities, National Society for the Prevention of Blindness, Inc., New York, N. Y.

(To be continued)

SAFETY IN PUPIL TRANSPORTATION

Nurses concerned with the problem of transportation of school children by bus will be very much interested in a study, published under this title, of the cause and prevention of bus accidents.* The report outlines (1) qualities which characterize competent drivers, (2) essential safety equipment, (3) desirable driving practices, (4) dangers to be avoided in selecting routes, (5) rules for pupil conduct, (6) a program of safety promotion, (7) the business practices affecting pupil safety. It also includes ten commandments for safe driving, questions and a score for a safe driving examination, and a check list of important safety standards and practices.

The report emphasizes the need for more effective legislation and more careful and continuous supervision of pupil transportation by state and local authorities.

*Safety in Pupil Transportation. Research Bulletin, National Education Association, 1201 Sixteenth Street, N.W., Washington, D. C. November 1936.

School nurses will be especially interested in an editorial on page 2.0; "Health Teaching in a Secondary School," by Mary E. Bowen, on page 292; "Forms for Reporting School Health Service," by Anna J. Miller, on page 315; and reviews and book notes on school health publications, pages 335 and 337.

EDITED BY
ELEANOR W. MUMFORD

NATIONAL HEALTH SERIES

Prepared under the auspices of the National Health Council and written by leading health authorities. Funk and Wagnalls Company, New York, 1937. 35c each, 3 for $1.00.

The titles of the books are: Adolescence, Cancer, Common Cold, Common Health, Diabetes, Exercise and Health, Expectant Mother and Her Baby, Healthy Child, Food for Health's Sake, Hearing Better, How to Sleep and Rest Better, Human Body, Love and Marriage, Staying Young Beyond Your Years, Taking Care of Your Heart, Tuberculosis, Venereal Diseases, What You Should Know About Eyes, Why the Teeth, Your Mind and You.

Very gay and youthful they look in their stiff covers and bright new dresses of colored cloth, these little volumes of the new National Health Series. Nor is their youth merely superficial. The series has truly been born again. As the publishers put it, there are 20 volumes, some completely revised, the others published for the first time. The editors have sought to select for each volume "an author of outstanding prominence who could present his material in a manner that would be readable and comprehensible to lay people." Undoubtedly they have found authors of prominence; the second and more difficult objective has been attained as often as might reasonably be expected.

But not entirely in every case. For example we read in the volume, "Hear Better":

> Much interest, today, is displayed in dietary situations, principally in vitamine and calcium deficiencies and sensitization to certain proteins. Likewise, in constipation and the retention of poisons combined with deficiencies of the pancreatic ferments.

It is extremely hard for the expert to realize the limitations both in vocabulary and in scientific preparation of the average "lay" reader. The collaboration of a newspaper man would have been valuable to several of these authors. But in every volume there is important information which public health nurses will do well to acquire and which they will be able to adapt when necessary to the needs of their constituents. For ourselves we shall use the series frequently in the preparation of short talks by radio or at luncheon clubs and for writing newspaper stories, and we shall recommend selected volumes to selected individuals in accordance with the latter's needs and intelligence.

J. Rosslyn Earp, Dr.P.H.
Santa Fe, New Mexico

PHYSICAL THERAPY FOR NURSES

By Richard Kovacs, M.D. 286 pp. Lea and Febiger, Philadelphia, 1936. $2.75.

Kovacs' "Physical Therapy for Nurses" is a bit technical for the student nurse, but if she is interested in this specialized field the book would prove of value in preparation for the necessary postgraduate training. As a textbook in a postgraduate curriculum in physiotherapy this treatise would furnish excellent background material.

It is not too much to hope that some day all nurses, especially in the field of public health, will have an understanding of the principles of physiotherapy, but interest in the subject is more likely to be aroused by a compendium of uses and results rather than a study of actual procedure.

Barbara A. Becker
Minneapolis, Minnesota

SCHOOL HEALTH PROBLEMS

By Laurence B. Chenoweth, M.D., and Theodore K. Selkirk, M.D. 387 pp. F. S. Crofts Company, New York, 1937.

This book treats of school health problems under eight main topics. The first chapters deal with the child—his development, his characteristics, his susceptibility to infection, and incidence of illness. These are followed by a discussion of the health examination, bringing in more facts about child growth and development. The chapters on communicable disease control place emphasis upon immunization and upon legal protection of the public, rather than upon the usual ineffectual methods of control through inspection and exclusion. Chapters on seeing and lighting, hearing and acoustics stress prevention through education as well as correction of defects. Selection of handicapped pupils for special classes, class organization, and transportation are briefly treated.

The chapter on mental hygiene approaches the subject through discussion of the glands of internal secretion, the environmental factors of mental hygiene, problem children and guidance personnel. In the chapter on physical education, the laws of learnings are discussed with reference to the learning of games and skills. The chapter on accidents presents excellent graphs showing incidence of accidents, and a long list of things to do and things to avoid in preventing accidents. The book concludes with an outline of school health administration contributed by Dr. Richard Arthur Bolt, which attempts to set forth basic principles. Each chapter is followed by an extensive bibliography.

The authors have collected from various sources a large body of facts dealing with the school-age child. These are presented in non-technical terms for the information of the classroom teacher and for her enlightenment with reference to the factors of health supervision, which should be included in any adequate school health program. The book should be widely read by teachers and by school nurses, for the better understanding of the child. Much of the factual material can be used as a basis for instruction, and the excellent graphs for visual instruction to high-school and parent groups.

MARY ELLA CHAYER, R.N.

THE DIAGNOSIS AND TREATMENT OF BEHAVIOR-PROBLEM CHILDREN

By Harry J. Baker, Ph.D. and Virginia Traphagen. 393 pp. The Macmillan Company, New York, 1935. $2.50.

In common with many of the books about the behavior problems of children this one devotes most of its space to diagnosis rather than treatment, and specifically to diagnosis by means of the Detroit Behavior Scale. The Scale has been evolved by the authors over a period of six years in the psychological clinic of the Detroit public schools. It consists of sixty-six items under the five headings of health and physical factors, personal habits and recreational factors, personality and social factors, parental and physical factors of the home, and home atmosphere and school factors.

When a child is studied, each item on the scale, as nearly as possible, is scored. A score of "very poor" is 1, "very good" is 5. The total score for all 66 items may therefore be anywhere from 66 to 330.

The authors believe that a systematic scheme such as this can contribute clarity to the thinking about the problem and to the treatment of it. They compare its use to that of mental tests, although they realize the great difficulties arising in any attempt to measure behavior motivations. They state repeatedly that the scale must not become routinized and that long experience and insight are necessary in the interpretation and evaluation of findings.

SYBIL H. PEASE
New York, N. Y.

FOOD FOR THE YOUNG CHILD

By Miriam E. Lowenberg. Collegiate Press, Inc., Ames, Iowa, 1934. $1.50.

This attractive little book would be valuable for mothers or workers responsible for feeding preschool children. It was developed at the Nursery School at Iowa State College to meet the requests "for adequate and satisfactory menus for preschool children and the recipes for the foods specified in the menus."

The book deals with the ever-present problem of meal planning and considers the factors of color, texture, and flavor, as well as food value. It discusses the principles of food preparation and the part that attractive, well cooked food plays in developing good food habits.

There is an interesting chapter on meal service with suggestions for inexpensive, attractive china and decorations which appeal to children. For example, "Three small sprigs of pussy willow in a tiny pottery bud vase were more interesting to the children at the Nursery School at Iowa State than were choice cut flowers."

The formation of good food-habits is discussed with some helpful suggestions. The dinner menus for one year and the recipes, both for family-size and for a large quantity, will appeal to busy mothers and workers. The beautiful photographs of children at work and play and the delightful verses at the beginning of each chapter give the book additional charm. To quote only one:

Dessert

Sometimes I should like to take
Apple sauce with yellow cake
Or perhaps I'd take instead
One large piece of gingerbread.
But always, if they'd never squirt,
I'd take oranges for dessert.

BLANCHE DIMOND
Boston, Massachusetts

RECENT PUBLICATIONS AND CURRENT PERIODICALS

GENERAL

THE FORGOTTEN FAMILY REMEMBERED. I. Malinde Havey. *The Red Cross Courier*, Vol. XVI, No. 8, February 1937. p. 7.

TUBERCULOUS COWS AND HUMAN TRAGEDY. Lona L. Trott. *The Red Cross Courier*, Vol. XVI, No. 8, February 1937. p. 15.

A HEALTH PROGRAM FOR STUDENT NURSES. Leonhard Felix Fuld, Ph.D. *The Health Officer*, Vol. 1, No. 9, January 1937. U. S. Treasury Department, Washington, D. C.

Such a program should prove effective in reducing the amount of time lost by nurses on account of illness, and should also make the nurse more appreciative of preventive health measures for herself and others.

THE FUNDAMENTALS OF PERSONAL HYGIENE. Second edition. Walter W. Krueger. W. B. Saunders Company, Philadelphia, 1936. 294 pp. $1.75.

A BIBLIOGRAPHY OF SUPPLEMENTARY MATERIAL FOR CLASSES IN HOME HYGIENE AND CARE OF THE SICK. Public Health Nursing and Home Hygiene and Care of the Sick, The American Red Cross, Washington, D. C. Prepared for authorized instructors. To other public health nurses, 10c a copy.

WAISTLINES. W. W. Bauer, M.D. Life Conservation Service of the John Hancock Mutual Life Insurance Company, Boston, Mass. Free.

COUNCIL RESEARCH AND FACT FINDING. Ellery F. Reed, Ph.D. Reprinted from *Social Forces* for December 1936.

This summarizes an extended experience of a sociologist in the active field of social work.

THE FAMILY AND COMMUNITY HEALTH. W. W. Bauer, M.D. *The National Parent-Teacher Magazine*, February 1937, p. 10.

HEALTH INDICES. A Study of Objective Indices of Health in Relation to Environment and Sanitation. K. Stouman and I. S. Falk. *The Milbank Memorial Fund Quarterly*, Vol. XV, No. 1, January 1937, p. 5.

A report of a system of appraisal based on health indices, considered more flexible than the standard of the American Public Health Association appraisal form. It includes a foreword by Dr. C.-E. A. Winslow.

HEALTH AND DISEASE IN THE MAGAZINES. *The Journal of the American Medical Association*, Vol. 108, No. 8, February 20, 1937, p. 643.

Public health nurses seeking evaluation of scientific, medical, or health information in articles in popular magazines will be interested in this editorial.

NURSING IN DISEASES OF THE EYE, EAR, NOSE AND THROAT. Sixth edition. Members of the Staff of the Manhattan Eye, Ear and Throat Hospital, New York, N. Y. W. B. Saunders Company, Philadelphia, 1937. 299 pp. $2.25.

PSYCHIATRIC RESOURCES FROM THE STANDPOINT OF SOCIAL AGENCIES. Stanley P. Davies. *Better Times*, Vol. XVIII, No. 18, February 1, 1937, p. 3.

As applicable to public health nursing agencies as to social work agencies.

SALIENT PUBLIC HEALTH FEATURES OF RHEUMATIC HEART DISEASE. O. F. Hedley. *Public Health Reports*, Vol. 52, No. 6, February 5, 1937, p. 164. Superintendent of Documents, Washington, D. C. 5c.

LIVE WITH HEART DISEASE—AND LIKE IT. Louis F. Bishop, Jr. and Ruth V. Bennett. *Hygeia*, March 1937, p. 220.

The second of a series of articles which present in practical and popular style the essential facts of learning to live with a heart defect. With the articles is included a list of suggested activities for persons with impaired hearts.

INFANCY AND PRESCHOOL

CONSERVATION OF VISION—INFANT AND PRESCHOOL AGE. Albert Frost, M.D. *Sight-Saving Review*, December 1936, pp. 286-94.

Special emphasis on cross eyes and congenital cataracts.

YOUNG CHILDREN IN EUROPEAN COUNTRIES. Mary Dabney Davis. Office of Education, U. S. Department of the Interior, Washington, D. C. 108 pp. For sale, Superintendent of Documents, Washington, D. C., 15c.

Report of a study made in preparation for the development of the Emergency Nursery School Project in this country under the ERA. It includes a chapter on health and nutrition and considers also the value of parental education in the various programs.

MENTAL HYGIENE

WHAT'S WRONG WITH VIOLATORS? Alan Canty. *Public Safety*, Vol. 12, No. 3, March 1937, p. 15.

A psychoanalytic approach to traffic violations.

BEFORE AND AFTER—THE DOCTOR COMES. Elizabeth Cheney Blackburn. *The National Parent-Teacher Magazine*, Vol. 31, No. 5, January 1937, p. 16.

This is an excellent article on the parental attitudes which influence those attitudes displayed by children toward the physician.

MENTAL HYGIENE PROGRAMS IN SCHOOLS AND COLLEGES. Charles E. Shepard, M.D. *American Journal of Public Health*, Vol. 27, No. 1, January 1937, p. 67.

An appeal for a positive, integrated program of mental health in schools and colleges. Stresses importance of early recognition and treatment. More courses in mental hygiene are available to all students in education, especially those entering the field of counseling.

SCHOOL HEALTH

HOW THE NURSE CAN COÖRDINATE AND PROMOTE THE SCHOOL HEALTH PROGRAM. Helen C. Manzer. *The Journal of Educational Sociology*, Vol. 10, No. 4, December 1936, p. 194.

This article is a clear exposition of the place of the school nurse in the school health program.

SALIENT PUBLIC HEALTH FEATURES OF RHEUMATIC HEART DISEASE. O. F. Hedley. *Public Health Reports*, Vol. 52, No. 6, February 5, 1937, p. 164. Superintendent of Documents, Washington, D. C. 5c.

This article is significant for all public health nurses but especially for school nurses. The importance of the school health department in control of the problem is stressed.

AN APPROACH TO THE PROBLEM OF SCHOOL MEDICAL AND DENTAL SERVICE. D. F. Smiley, M.D. *The Journal of the American Medical Association*, Vol. 108, No. 6, February 6, 1937, p. 435.

A discussion of two very controversial subjects: (1) health supervision of the school-age group by the private physician and dentist or by the school medical service; (2) should the school health service be under the board of health or board of education?

THE TEACHER IMPROVES THE DENTAL HEALTH OF THE CHILDREN. Essex County Mouth Health Committee. 1936. 32 pp. Copies may be obtained from Edith M. Lurcott, Executive Secretary, Council on Mouth Hygiene, 1143 East Jersey Street, Elizabeth, N. J. 25c.

Outline of dental information with suggested methods by which parents and school staff contribute to the dental health program.

SAVE THE INJURED. Sergeant A. J. Hagel. *Public Safety*, Vol. 12, No. 3, March 1937, p. 25.

First aid for traffic victims.

• The American Public Health Association's 66th annual meeting will be held in New York City, October 5-8, for the first time since 1921. And for the first time, too, the National Organization for Public Health Nursing will meet with the American Public Health Association. The following related societies will meet with the Association as usual: The American Association of School Physicians, International Society of Medical Health Officers, Conference of State Sanitary Engineers, Conference of State Laboratory Directors, Association of Women in Public Health, Delta Omega.

Any inquiries may be directed to Dr. Reginald Atwater, Executive Secretary of the Association, at 50 West 50 Street, New York, N. Y.

• The annual convention of the American Red Cross will be held in Washington, D. C., May 10-13. The luncheon for Red Cross nurses will be held on the anniversary of Florence Nightingale's birthday, May 12.

• The New England Health Education Association's twelfth annual meeting will be held at the Massachusetts Institute of Technology, Cambridge, Massachusetts, June 4 and 5.

• The New York State Conference of State, County, and City Committees on Tuberculosis and Public Health of the State Charities Aid Association will be held at the Hotel Roosevelt, New York, N. Y., May 11-13.

• The Commonwealth Fund's public health program for 1937 will include the subsidizing of two counties, one in Mississippi and one in Tennessee, to make possible an intensive local demonstration in each state, which it is hoped will help to reinforce state-wide efforts in public health. Jones County, Tennessee, has been chosen by the State Health Department and the Fund for one demonstration. The Fund will continue its appropriation toward state-wide public health services in Tennessee, Mississippi, and Massachusetts, for the maintenance and development of medical education in these States, and for local demonstration services on a modified scale.

• The Board of the Visiting Nurse Association of Cleveland, Ohio, has presented Elizabeth M. Folckemer with a present of a trip abroad to attend the International Congress of Nurses held in London this summer. Miss Folckemer, now Director of the Association, has been identified with it since 1914.

• May 23-29 is the week set aside for the 64th annual meeting of the National Conference of Social Work, which will meet this year in Indianapolis, Indiana. With more than three hundred daily sessions scheduled for the week of the meeting, the program will cover all phases of current social welfare.

• The Social Security Board and the Civil Service Commission have issued a warning against lavish promises made by self-styled "social security correspondence schools" and mail-order training courses which claim to prepare individuals for social security jobs. Such courses, the joint statement of the Board and the Commission said, are being offered by mail and personal solicitation, and in some cases by salesmen posing as government representatives.

• The Julius Rosenwald Fund has made a grant of $165,000 over a five-year period to the Committee on Research in Medical Economics. This committee has recently been incorporated in New York, with Michael M. Davis as chairman. The committee will conduct and assist studies in the economic and social aspects of medical care; will train personnel for this field; and in coöperation with the medical profession and other agencies, will furnish information and consultation services in behalf of rendering medical care more widely available to the people at costs within their means. The headquarters of the committee will be in New York City.

• The twenty-second National Recreation Congress will meet in Atlantic City, May 17-21, at the Ambassador Hotel. Laymen and executives from all parts of the United States will meet to discuss the problems of youth, the enlistment and training of board members and volunteers, recreational programs, interpretation of the work to the public, and problems of administration. Further information may be secured from T. E. Rivers, 315 Fourth Avenue, New York, N. Y.

• A certificate for distinguished public service was conferred on Lillian D. Wald by Mayor Fiorello H. LaGuardia of New York City, on March 10, the occasion of Miss Wald's seventieth birthday. The ceremony was broadcast from the headquarters of the Henry Street Visiting Nurse Service Miss Wald listened from her bedside in Westport, Conn.

The East Side playground at Montgomery and Gouverneur Streets will be known as the Lillian D. Wald playground, the Mayor announced.

• A study is being made by the Baltimore Health Department in coöperation with the Baltimore City Medical Society to determine the underlying causes of maternal deaths in Baltimore, according to the report of the Bureau of Child Hygiene of the Baltimore Department of Health contained in the Department's annual report for 1935. The study is being made by means of detailed investigation and subsequent analysis of every fatality from puerperal causes. It is hoped that it will result in recommendations for measures that will reduce maternal and infant morbidity and mortality rates.

• The National Research Council's Division of Engineering and Industrial Research has arranged a European tour for American industrialists to observe the research laboratories of eighteen major fields of industry in England, France, and Germany beside those of trade associations, governments, and universities. Foreign hosts will be such organizations as the Department of Scientific and Industrial Research in England, the Verein Deutscher Ingenieure in Germany, the Sorbonne in France, and others.

• The Fifth International Hospital Congress will be held in Paris, July 5-11. For further information write to the Secretary of the Congress, 9 bis, Avenue d'Iena, Paris 16e.

• The new Nurses' Home at the Rhode Island State Sanatorium for Tuberculosis has been designated as the "Fitzpatrick House." It has been named in honor of Winifred L. Fitzpatrick, Director of the Providence District Nursing Association, in appreciation of her interest in the State Sanatorium's welfare and tuberculosis work in general. It is the first of a group of buildings being constructed by the Public Welfare Administration.

The building will accommodate sixty-five nurses. There are two solariums, a dining room which will use cafeteria service, two diet-kitchens and sixty sleeping rooms. The Home is modern and up to date and is beautifully furnished.